DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Grant Appeals Board

Office of Hearings for Civil Money Penalties

In the Case of:

The Inspector General,

-v.-

Frank P. Silver, M.D.,
Respondent

Date: July 2, 1987

Docket No. C-19
CR 10

DECISION AND ORDER ON REMAND

In this case, the Inspector General (I.G.) of the United States Department of Health and Human Services (DHHS) issued a Notice of Determination (Notice) informing Frank P. Silver, M.D. (the Respondent), that the I.G. sought a penalty of $232,000, an assessment of $18,000, and a ten year suspension of the Respondent from participating as a medical provider in the Medicare and Medicaid programs. In the Notice, the I.G. alleged that the Respondent had violated the Civil Monetary Penalties Law (CMPL) and its implementing regulations (Regulations) by presenting or causing to be presented four hundred twenty (420) false or improper claims for Medicaid and Medicare payment, involving twelve hundred forty-four (1244) laboratory tests, during the period August 13, 1981 through May 1983.[1][2]

The Respondent, a licensed physician in Las Vegas, Nevada, specializing in the practice of obstetrics and gynecology, filed

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

[2]The terms “civil monetary penalties” and “civil money penalties” are used interchangeably in the CMPL, the Regulations, and in this Decision and Order.

a timely answer denying the I.G.'s allegations, challenging the proposed sanctions, and requesting a hearing before an Administrative Law Judge (ALJ). On July 11, 1986 this ALJ issued a Decision and Order, finding the Respondent liable under the CMPL and Regulations for presenting or causing to be presented 418 Medicaid claims for laboratory tests that were not provided as claimed, and imposing a penalty of $232,000, an assessment of $9,237.59, and a suspension from the Medicaid and Medicare programs for a period of ten years.[3]

After reviewing the Respondent's exceptions to the Decision and Order, the Deputy Under Secretary issued an Opinion and Order Opinion) on April 27, 1987, which reversed the Decision, vacated the Order, and remanded this case "for proceedings not inconsistent" with the Opinion. The Opinion (at p. 2) concluded that an individual may be subject to liability under the CMPL "even though his conduct is merely negligent," that the Respondent "may not be subject to vicarious liability," and that the incorrect standard was applied in judging liability.[4]

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[3] I also held that: (1) the I.G. did not prove by a preponderance of the evidence that improper Medicare claims were presented (leaving only Medicaid claims at issue in this case); and (2) the I.G. failed to give adequate notice with regard to two claims.

[4] The incorrect standard was urged by the I.G. and adopted in the Decision. At the time, I was influenced by the following part of the preamble to the Regulations: (T)he language just quoted ("knows or has reason to know") indicates that Congress intended to subject to civil money penalty liability those who present or cause to be presented claims for items or services that they did not know, but should have known, were not provided as claimed (emphasis added). 48 Fed. Reg. 38831 (August 26, 1983). In a subsequent Decision, issued by me on December 22, 1986, the "reason to know" standard was applied and the "should have known" standard was disavowed. *See* The Inspector General v. Jimmy Paul Scott, OHCMP/DGAB Docket No. C-15. The Scott Decision has been, in effect, affirmed by the Deputy Under Secretary and is now final. Shortly after the Scott Decision was issued, the Deputy Under Secretary remanded this case. Although the Deputy Under Secretary's Opinion fails to mention the quoted language in the preamble, the Opinion tacitly rejects and, thus, invalidates it.

THE GOVERNING LAW AND REGULATIONS

I. General Provisions of the Civil Monetary Penalties Law and Regulations

Section 1320a-7a of the CMPL (section 1128A of the Act) grants authority for the I.G. to issue a Notice to impose civil money penalties and assessments against a medical provider who the I.G. determines: (1) has presented or caused to be presented false or improper claims for payment under the Medicare, Medicaid, or the Maternal and Child Health Services Block Grant programs; or (2) has presented or caused to be presented a request for payment to a Medicaid recipient or Medicare beneficiary in violation of the terms of a respondent's Medicaid or Medicare provider agreement.[5] *See* Regulations section 1003.102. Once a respondent subject to a penalty or an assessment, section 1320a-7(c) of the CMPL (section 1128(c) of the Act) grants authority for the I.G. to include a proposal to suspend the medical provider from participation in the above named public assistance programs. *See* Regulations sections 1003.105, 1003.107.

The intended purpose of imposing a civil money penalty is to deter persons from presenting improper Medicare or Medicaid claims (or from making requests for payments to Medicaid recipients in violation of a provider agreement); the purpose of imposing an assessment is to make the government whole for its costs and any damages resulting from such improper acts; the purpose of a suspension is to protect program integrity. *See* H.R. Rep. No. 97- 158, 97th Cong., 1st Sess. Vol III, 329; Preamble to the Regulations (48 Fed. Reg. 38827 to 38836, August 26, 1983).

The Regulations implement the provisions of the CMPL, delegate authority from the Secretary to the I.G. to make determinations regarding civil monetary penalties, and provide a respondent the right to a hearing before an ALJ. The I.G. has the burden of producing and proving by a preponderance of the evidence (1) liability under the CMPL and Regulations, and (2) aggravating circumstances. A respondent has the burden of producing and proving by a preponderance of the evidence any mitigating

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[5] A person eligible for Medicaid benefits is defined at 42 C.F.R. section 430.1 as a "recipient." Medicaid recipients may at times also be referred to in this Decision and Order as Medicaid beneficiaries or patients.

circumstances that would justify reducing the amount of the penalty, assessment, and suspension. Regulations section 1003.114.

The CMPL and Regulations provide for a civil money penalty of "not more than $2,000" for each improper item or service listed on each improper claim; the amount of the assessment is not to be more than twice the amount claimed. Regulations section 1003.103. There is no such limit on the length of a suspension. The Regulations require that a full and fair trial-type hearing be conducted by an ALJ. Regulations section 1003.115. Within 60 days of an ALJ's decision and order, either party may seek review by the Secretary of DHHS; judicial review may also be sought. Regulations sections 1003.125, 1003.127. Judicial review of penalties and assessments is in the appropriate United States Court of Appeals, and judicial review of a suspension is in the appropriate United States District Court.

II. Liability Under the CMPL and Regulations

A. Requisite Proof to Establish Liability

Liability will not attach under the CMPL and the Regulations unless the I.G. establishes liability by a preponderance of the evidence adduced during the proceedings in a case. The Regulations allow the I.G. to establish liability in either of two distinct ways. The first requires the I.G. to prove the merits of the case by a preponderance of the evidence. To do this, the I.G. must prove each of the requisite elements of liability set forth in the CMPL and Regulations for each "item or service listed" on each "claim" that the I.G. alleges to be improper. *See* CMPL section 1320a-7a; Regulations sections 1003.102, 1003.114(a).[6][7] The second manner of establishing liability is akin to collateral estoppel and is established if the I.G. proves that a "final determination" has been rendered

[6]Section 1320a7a(h)(2) of the CMPL and section 1003.101 of the Regulations define a "claim" as an application for payment submitted for one or more items or services for which payment may be made under the Medicare (Title XVIII), Medicaid (Title XIX), or Maternal and Child Health Services Block Grant (Title V) programs.

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

against a respondent in a prior proceeding (within the meaning of section 1003.114(c) of the Regulations).

B. The Two Primary Bases for Liability

There are two primary bases upon which a person can be subject to liability under the CMPL and Regulations. *See* Regulations section 1003.102(a)(1) and (b)(1).[8] Each has its own elements (or standards) which must be proven in order for liability to attach. The first basis for liability requires the I.G. to establish that false or improper claims were presented or caused to be presented by a respondent and the claims contained items or services which the respondent "knew or had reason to know" were "not provided as claimed." CMPL section 1320 a-7a(1)(A); Regulations section 1003.102 (a)(1). The second basis for liability under the CMPL and Regulations requires the I.G. to establish that a request for payment was presented or caused to be presented to a Medicaid recipient or Medicare beneficiary by a respondent, and that such action violated a provider agreement or other agreement. CMPL section 1320a 7a(B)(2); Regulations Section 1003.102(b)(1). The most significant difference between these two bases of liability is that scienter is not required for liability to attach under the second basis.[9]

III. The Medicaid Law and Program in Nevada

The Medicaid program (Title XIX of the Act; 42 U.S.C. section 1369, et seq.) was created by Congress to assist in providing medical care to needy persons. If a state chooses to have a

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

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

Medicaid program, it must submit, for approval by the Secretary of DHHS, a State Plan which meets federal statutory and regulatory requirements.

The Nevada Department of Human Resources (NDHR) is the designated state agency responsible for administering the Nevada Medicaid program. The Medicaid program is referred to as "State Assistance for the Medically Indigent" (SAMI). NDHR is responsible for establishing policy, rules, and regulations regarding the proper submission of Medicaid claims for payment by medical providers in Nevada. In order to facilitate the processing and payment of claims for reimbursement, NDHR contracted with Blue Shield of Nevada (BSN) to serve as the fiscal intermediary for the Nevada Medicaid program. I.G. Stip. B 4; TR I/210.[10]

JURISDICTIONAL AND PROCEDURAL BACKGROUND

The I.G.'s Notice was issued on August 2, 1985. In the Notice, the I. G. alleged that 1244 line items for services claimed by the Respondent in the 418 claims at issue were improper because the Respondent or his billing clerk improperly represented (with the use of a procedure code on the claims) that the Respondent had paid independent commercial laboratories to perform various laboratory tests, including urine cultures, pap smears, and urinalysis, and argued that the Respondent knew, had reason to know, or should have known that these claims were improper. The I.G. argued that (1) in cases where the lab tests were actually performed, the Respondent had not paid the labs for the services, but, in fact, the labs billed Medicare or Medicaid and were paid directly by Medicare or Medicaid (resulting in a situation where both the Respondent and the labs were paid by the Medicare and Medicaid programs) and, (2) in other instances, the Respondent submitted claims for the performance of lab tests which were never ordered or were never performed.

In the Respondent's answer and request for a hearing, dated Sept. 6, 1985, the Respondent admitted that his billing clerk submitted the claims at issue, but argued that (1) his billing

[10] The record contains a set of proposed stipulations submitted by each party. At the hearing, each party adopted some of the other party's stipulations. TR I/9 to Il. Each stipulation agreed to will be referenced as follows: "I.G. Stip/ (number)" (the stipulations presented by the I.G. and agreed to by the Respondent) or "R Stip/ (number)" (the stipulations presented by the Respondent and agreed to by the I.G.).

clerk simply made errors, (2) these errors were obvious to Medicaid from the face of the claims at issue, (3) he was at most negligent in supervising an employee, (4) only gross negligence is actionable under the CMPL and Regulations, and (5) if some liability is found, the penalties should be minimal because of lack of culpability and because of other mitigating factors such as contributory negligence resulting from governmental actions and error. The Respondent also argued that: (1) the penalties provided for by the CMPL are unconstitutionally disproportionate to the offense committed by the Respondent; and (2) the spirit of the CMPL and Regulations require the I.G. to reduce the amount of penalties by following an internal I.G. policy of twenty times the amount misbilled.

A Prehearing Conference was held in Reno, Nevada on October 25, 1985. A formal Hearing was held in this case in Las Vegas, Nevada from January 13, 1986 to January 16, 1986. Eight witnesses testified on behalf of the I.G. and five witnesses testified on behalf of the Respondent, including the Respondent. The I.G. and the Respondent each presented a post-hearing brief, proposed findings of fact and conclusions of law, and a reply brief.

On remand, the I.G. submitted a brief, the Respondent submitted a brief in opposition, and the I.G. submitted a reply brief. The I.G. argues that there is ample evidence in the record to support a finding that the Respondent “had reason to know” that the claims at issue were for services not provided as claimed, and that the Respondent is liable for the proposed penalty, assessment, and suspension. I.G.Rem Br/2, 30.[11] The Respondent

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[11] Reference to the briefs, the transcript, the stipulations, hearing exhibits, and to these Findings of Fact and Conclusion of Law are as follows:

I.G.’s Brief on Remand = I.G.Rem Br/(page); I.G.’s Reply Brief on Remand = I.G.Rem Rep Br/(page); Respondent's Answer Brief on Remand = R Rem Br/(page); I.G.’s Brief I.G. Br/(page); I.G.’s Reply Brief = I.G. Rep Br/(page); Respondent’s Brief = R Br/(page); Respondent’s Reply Brief = R Rep Br/(page); Transcript = TR (volume number)/(page); Stipulations submitted by the I.G. = I.G. Stip/(number); Stipulations submitted by the Respondent = R Stip/(number); I.G. Exhibit = I.G. Ex (number)/(page); Respondent's Exhibit = R Ex (number)/(page); ALJ Findings of Fact and Conclusions of Law = FFCL/(number)

denies there is credible evidence to support such a finding. R/Rem Br/1. On May 14, 1987, I.G. Exhibits P and Q were admitted into evidence, with no objection, during a telephone conference with the parties. I. G. Exhibit P is the affidavit of Jeanette Romer. I.G Exhibit O is a claim form-showing the physician's certification. On June 17, 1987, I. G. Exhibit R was admitted into evidence with no objection. I.G. Exhibit R is a letter dated June 4, 1987, to the I.G. from the Clark County Medical Society. On May 20, 1987, Respondent's Exhibit 7 was admitted into evidence over the objection of the I.G. (on relevancy grounds) during a telephone conference. Respondent's Exhibit 7 consists of (1) an October 10, 1986 letter to Dr. Silver from the Clark Co. Medical Society; and (2) an attached affidavit from Joseph Kelly, Esq.

ISSUES

1. Whether the I.G. proved by a preponderance of the evidence that the Respondent "had reason to know" that his bookkeeper was presenting improper claims to the Medicaid programs; and, if so,

2. Whether the amount of proposed penalty, assessment, and suspension are appropriate "under the circumstances of this case."

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having reconsidered the entire record, the arguments and submissions of the parties, and being advised fully herein, I make the following Findings of Fact and Conclusions of Law:[12][13]

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[12]Some of the proposed findings and conclusions offered were rejected because they were not supported by the evidence in the record, needed to be modified, or were not material; others were rejected because there were conflicts between the documentary evidence and the testimony, or between the documentary evidence and the stipulations. Also, I have incorporated some findings and conclusions elsewhere in this Decision.

[13] Any part of this Decision and Order preceding the Findings of Fact and Conclusions of Law which is obviously a finding of fact or conclusion of law is hereby incorporated herein as a finding of fact or conclusion of law. I refer primarily to the facts and conclusions that were not disputed or which are clear and do not need to be repeated here.

1. For the purposes of these proceedings, I have taken judicial notice of the statutes of the United States, the regulations of the Secretary of DHHS, all other pertinent regulations of the United States, the statutes of the State of Nevada, the regulations of the Nevada Medicaid Program and all other pertinent regulations of the State of Nevada as they existed at the time of the cause of action. I.G. Stip. A 1; TR I/9, 128.

2. The Secretary delegated authority to the I.G. and his delegates to take action under the CMPL (i.e., sections 1128A and 1128(c) of the Act) pursuant to the Regulations and delegations of authority dated April 18, 1983, July 27, 1983, September IS, 1983, and September 26, 1983. I.G. Stip. A 3 to 6; TR I/9; 50 Fed. Reg. 37371 (September 13, 1985).

3. The Notice or Determination dated August 2, 1985, notified the Respondent that the I.G. had determined that the Respondent should be subject to penalties of $232,000, assessments of $18,000, and suspension from participation in the Medicaid and Medicare programs for a period of ten years, alleging that the Respondent presented or caused to be presented to Aetna, the carrier for Medicare, and to Blue Shield Nevada, the carrier for Medicaid, from about September 1981 through about May 1983, false or improper claims 1244 line items or services which the Respondent knew or had reason to know were not provided as claimed, in violation of the CMPL and Regulations. At the hearing, the I.G. noted that: (1) the Notice had incorrectly stated the number of claims at issue to be 516 when, in fact, the correct number was 420; and (2) the number of line items or services alleged to be false or improper remained the same (i.e. 1244). The 420 claims containing the 1244 line items or services alleged to be false or improper are listed in the attachment to the I.G.’s Notice of Determination. A true and correct copy of this Notice and its attachment is a part of the record in this case. I.G. Stip. B 1, 2, 7; TR I/6; TR II/363.

4. The Respondent, by letter dated September 6, 1985, filed an answer to the Notice and a request for a hearing before an ALJ, pursuant to section 1003.109(b) (2) of the Regulations. A true and correct copy of the answer and the defenses listed therein is a part of the record in this case.

5. Of the 420 claims in evidence in this case, two were neither listed in the Attachment to the Notice of Determination nor in any amendment or other notice to Respondent (I.G. Ex 419 and 420). Thus, those claims are stricken for lack of notice and are not a part of this case. Accordingly, the number of claims at

issue is reduced to 418. The number of line items or services at issue remains 1244.

6. Dr. Frank Silver, the Respondent, is a physician specializing in gynecology and obstetrics. He was licensed to practice in the State of Nevada during the entire period involved in this case. TR III/507.

7. The Nevada Department of Human Resources (NDHR) is the State Medicaid Agency. NHDR has been authorized to administer the Nevada Medicaid Program, also known as State Assistance to the Medically Indigent (SAMI). I.G.Stip. B3; TR I/9, 15.

8. Blue Cross/Blue Shield of Nevada (hereinafter referred to as "Blue Shield Nevada" or "BSN") has served as the Medicaid fiscal intermediary (carrier) for NDHR for administering SAMI. I.G. Stip B 3; TR I/9, 15.

9. Prior to submitting any of the SAMI claims for reimbursement which are the subject of this proceeding, the Respondent had enrolled with BSN as a Physician providing services to Medicaid recipients. The Respondent submitted claims for SAMI reimbursement from 1973 through the dates at issue in this case. I.G. Stip. 9 6; TR I/38, 40, 44, 549.

10. BSN received, reviewed, and processed claims for services rendered to SAMI recipients. Such claims are subject to specific requirements governing the filing of claims for SAMI reimbursement. I.G. Ex 426; I.G. Stip. B 5; TR I/148.

11. To ensure compliance with its regulations and requirements, SAMI issued to all participating providers froth Medicaid Physician Billing Manuals (Billing Manual) and SAMI Bulletins (Medicaid Bulletins), designed to highlight and clarify the Billing Manuals. Such information was sent to the providers' billing addresses. I.G. Stip. B 9; TR I/ 143, 144, 146; TR II/215-216; I.G. Ex 426, I.G. Ex F.

12. As with all other participants in the SAMI Program, the 1981 and 1982 billing manuals and all educational bulletins were sent to the Respondent at his billing address. Respondent's office was his billing address. TR I/100, TR II/216.

13. Blue Shield Nevada promulgated and disseminated the Billing Manual, which was revised in May 1981, April 1982, and September 1985. A true and correct copy of the April 1982 version of the manual is in evidence in this case as I.G. Ex 426. *See* I.G.

Stip./B 5. The 1982 Billing Manual was accompanied by a cover letter, “Dear Doctor:...”, which, in part, read: “This manual has been addressed to your personal attention with the hope that you will request your billing staff to read it carefully." I.G. Ex 426/1.

14. True and accurate copies of certain Medicaid Bulletins are in evidence in this case. They are: Bulletin #86(issued April 18, 1977), Bulletin #121 (issued December 10, 1979), Bulletin #131 (issued October 7, 1980) Bulletin #132 (issued October 7, 1980), Bulletin #134 (issued October 13, 1980), and Bulletin #146 (issued June 22, 1981). I.G. Ex 426, F.

15. Any provider of services to the SAMI program is required to either sign the claim personally or initial the claim and use a signature facsimile stamp. The signature constitutes a certification that all the information on the billing form is true, accurate and complete. I. G. Stip. B 7; I.G. Ex 426/8; TR I/43, 47-48; TR III/549.

16. Of the 418 claim forms submitted or caused to have been submitted by the Respondent, 341 were submitted on “HCFA 1500” forms, and 65 on “AMA-I” forms. I.G. Ex 426/7-10. The remaining 12 claims were filed on forms with no specific certification of truth and accuracy. I.G. Ex 214-218, 220, 226-228, 266, 306, 392.

17. In using the HCFA 1500 form, the Respondent by his signature or his signature stamp certified to the truth, accuracy and completeness of the claim. At Block 25 of the HCFA 1500, the words “SIGNATURE OF PHYSICIAN OR SUPPLIER,” are followed by the words “I certify that the statements on the reverse apply to this bill and are made a part hereof,” followed by the signature space. The reverse side of the HCFA 1500 form states, with respect to Medicaid Payments: “NOTICE: This is to certify that the foregoing information is true, accurate and complete.” I.G. Ex. 426/8, I.G. Ex P.

18. In using the AMA-I form, the Respondent by his signature or his signature stamp certified to the truth, accuracy and completeness of the claim. At Block 25 of the AMA-l, the words “SIGNATURE OF PHYSICIAN OR SUPPLIER,” are followed by the words “Read back before signing,” followed by the signature space. The reverse side of the AMA-1 form states, with respect to Medicaid payments: “NOTICE: This is to certify that the foregoing information is true, accurate and complete.” IG Ex P, Q.

19. In using the form without a specific certification of truth and accuracy, the Respondent was not liable under the CMPL for the truth, accuracy, and completeness of the claim absent other circumstances giving rise to a duty to investigate the truth, accuracy, and completeness of the claim.

20. In 1981, Respondent was the top physician biller to SAMI, and was among the top five physician billers to SAMI during each of the five years prior to trial. TR II/182.

21. During 1982, 47 percent of the line items in Respondent's billings to SAMI (1,154 of 2,438) were for laboratory services. During the first five months of 1983, 47 percent of the line items in Respondent's billings to SAMI (440 of 932) were for laboratory services. IG Ex M; TR IV/664.

22. The total dollar amount of laboratory items billed to SAMI by the Respondent was approximately three percent of the total amount billed to SAMI by the Respondent during the period at issue.

23. The Respondent authorized Mrs. Kathleen Eby to sign all the claims filed during the period involved here and to submit those claims to the SAMI program on his behalf. I.G. Stip. B/7; I.G. Ex 426/8; TR I/43, 47-48; TR III/549.

24. At all times relevant here, Mrs. Kathleen Eby was in charge of bookkeeping and billing functions for the Respondent. TR.I/38-39, 82, 100, 104; TR II/215-216; TR III/549-550.

25. Mrs. Kathleen Eby knew or had reason to know the relevant rules and regulations of the SAMI program. TR I/38-39, 100, 104; TR II/215-216; TR III/549-550.

26. The Respondent presented or caused to be presented to BSN the 418 claims for Medicaid reimbursement for at least 1244 items or services specified in the Inspector General's August 2, 1985 Notice letter. I.G. Stip. 9/7.

27. Of the claims listed in the attachment to the Notice, those for Melinda Johnson, Robiteen Brooks, Luandra Norris, and Maggie DeBarge are listed in duplicate; and the I.G. did not submit exhibits or other evidence of the claim for services rendered to Alice Connell on June 28, 1982. The duplicate claims are stricken, and the Inspector General did not prove that the Alice Connell claim was false or improper by a preponderance of the evidence.

28. The I.G. alleged that six (6) of the 420 claims listed in the Notice were crossover claims (i.e., were submitted to and processed by Medicare as well as Medicaid). The I.G. did not prove by a preponderance of the evidence that the six (6) crossover claims (Nos. 218, 220, 306, 359, 363; see, TR I/Il, 12) were submitted to or processed by the Medicare carrier (Aetna). There is proof (and the Respondent admits) that these same claims were submitted to the Medicaid carrier (BSN), were processed by the Medicaid carrier, and that payment was received by the Respondent from the Medicaid carrier. See R Rep Br/2, 3; cf., TR I/102.

29. The remaining 418 Medicaid claims at issue contain at least 1244 line items. Tr I/11; IG Ex 1-418. See, also, attachment to the I.G.'s Notice letter.

30. During the period at issue, services provided to SAMI recipients were billed using a procedure number from the 1974 Edition of the CRVS manual. TR I/169; TR II/286, 290; I.G. Ex 426/5, 14. The 1974 CRVS Manual was available prior to January I, 1976 and all physicians were notified by bulletins (such as #121). The 1974 CRVS became effective in Nevada as of January 1, 1976, and no billings were accepted after January 1, 1980 under any codes other than the 1974 CRVS. I.G. Ex 426/ 14, 15.

31. The Nevada Medicaid Program utilized the 1974 CRVS procedure codes as descriptors of services provided to Medicaid recipients, and these procedure codes had to be used when submitting claims to BSN at all times relevant to this action. The procedure codes, contained within the 1974 Revision of California Relative Value Studies (CRVS), also establish the fee schedule for services rendered by providers. A true and correct copy of the 1974 CRVS is in evidence in this case as I.G. Ex 431. I.G. Stip. B 8.

32. Bulletin No. 131, dated August 25, 1980, warned providers that "violations of the intent and language" of the 1974 CRVS is considered "abuse of the Medicaid program" and that such abuse would subject the provider to investigation and other sanctions. I.G. Ex 426/15.

33. Medicaid laboratory services are covered by the CRVS coding system, and the rules governing submission of claims for laboratory services are set out in the pathology section of the CRVS. I.G. Ex 431/3.

34. The correct CRVS code for billing a urinalysis test is 81000; a urine culture is coded 87086; a vaginal culture is coded 87040 or 87070; a pap smear is coded 88150 or 88155; a complete blood count is coded 85022.

35. When using the CRVS codes, the provider is indicating: (1) that the specified laboratory test has been performed by the provider, and he is seeking payment for that service; or (2) that an outside laboratory was used by the provider, that he paid the outside laboratory, and he is seeking reimbursement for his payment to the lab. I.G. Ex 431/37, 13, 18-19; I.G. Ex F/2; TR II/253, 286 (Testimony of BSN Claims Processor and Medicaid Utilization Control Specialist).

36. The correct CRVS codes for billing the collection and handling of a blood sample are 99018--99023. A provider may claim a blood drawing charge in addition to other services provided to the recipient, including an office visit, in situations where an outside lab analyzes the blood sample. I.G. Ex 431/5; TR I/168; TR II/255-256, 288.

37. In 59 of 65 claims in which blood tests were billed, the Respondent also billed a blood drawing charge. I.G. Ex 43, 50, 70, 77, 101, 117, 118, 123, 127, 134, 135, 136, 138, 339, 143, 146, 149, 171, 182, 184, 189, 213, 223, 240, 246, 252, 264, 278, 280, 297, 299, 301, 303, 306, 308, 310, 311, 313, 314, 319, 320, 324-327, 329, 345, 347, 358, 365, 367, 373, 381, 397, 400, 412, 414, 415, 418. cf. I.G. Ex 73, 288, 323, 351, 370, 401.

38. The correct CRVS codes to be used generally when billing for the collection and handling of specimens other than blood is 99007. This code may only be used when specimen collection is the only service provided and billed by the provider; this code may not be used in instances where there is an examination of the Medicaid recipient or an office visit charge to Medicaid and an outside lab performs the lab test. I.G. Ex 431/4, para. 9; TR I/81, 171-172; TR II/256, 287-288.

39. In 416 of the 418 claims at issue, the Respondent billed SAMI for both an office visit (using one of the CRVS codes in the 90000 series) and for one or more laboratory tests; in none of these did the Respondent perform the lab test. I.G. Ex 1-49, 51-357, 359-418.

40. In addition to the claims referred to in FFCL/38 above: (1) in I. G. Ex 50, the Respondent billed SAMI $10 for an injection under code 90730 (changed by the carrier to 90030, the proper

CRVS code for an injection) in addition to billing SAMI for a urinalysis, a urine culture, a blood test, and a blood drawing charge; and (2) in I.G. Ex 358, the Respondent billed SAMI $135 for a “pelvic ultra sound,” in addition to billing SAMI for a blood test, a blood drawing charge and an injection.

41. The Respondent’s billing clerk, Mrs. Eby, knew and understood the CRVS and SAMI rules and regulations on billing for laboratory tests and handling fees during the period at issue. TR I/63-76, 80-82; 125 to 202; I.G. Ex 422, 423, 426, 431; cf. I.G. Ex D (affidavit of Kathy Eby), E, F.

42. When submitting a claim for laboratory tests, the provider is required to indicate the laboratory where the test was performed. The provider may claim reimbursement for tests performed in his office only if the laboratory is certified by the Nevada Bureau of Laboratories and Research. I.G. Ex F/2; I.G. Ex 426/9-10; TR I/128, 151-152.

43. Prior to and during the relevant time period, the Respondent did not have the required certification needed to operate a testing laboratory in his office. I.G. Ex 421; TR 128, 130, 152; I.G. Ex III/ 540.

44. Under the SAMI rules and regulations in effect during the period at issue, a provider may claim reimbursement for lab tests performed by an independent laboratory only when he paid the laboratory for the service, was billing SAMI for reimbursement, and the cost of each test was itemized on the claim form. The provider was not required to submit the laboratory’s invoice for the tests performed; he was not required to indicate the cumulative lab charges in box 22 of the claim form. I.G. Ex 426/9, 10; I.G. Ex F/2; TR II/224-225, 253-254, 262-263.

45. On each of the 418 claims at issue, the Respondent’s billing clerk represented that the Respondent had reimbursed a commercial laboratory for the performance of between one and six tests. For each test for which reimbursement was sought, Mrs. Eby identified the service by the 1974 CRVS test procedure code, written description, and price claimed. However, the laboratories had not been reimbursed by the Respondent for such testing services, and the Respondent had “reason to know” that these claims were false as presented to SAMI. I.G. Ex I, 418; TR I/ 75-85, 83-91, 105-106; TR II/253, 268, 322-324; TR III/525.

46. On 91 of the 418 claims at issue, the Respondent's billing clerk (acting at the Respondent's behest) submitted claims indicating that laboratory tests had been performed by a laboratory. In fact, the tests were not performed at all, and the Respondent had "reason to know" that these claims were false as Presented to SAMI. TR II/ 335-343; TR IV/596, 623-648; I.G. Tx 1-67; I.G. Ex G; R Ex 3; I.G. Ex 171, 173, 176, 179, 180, 183, 192, 194, 195, 196, 253, 262, 263, 265, 278, 284, 291, 300, 311, 316, 333, 348, 350, 353, 359, lb - 67b; Ic - 67c, 171b, 171c, 179b, 180b, 180c, 1830, 1920, 19,c.

47. In 71 of the 418 claims at issue, the Respondent's billing clerk misidentified the commercial laboratory performing the itemized tests. This material misrepresentation could have resulted in the Respondent being reimbursed for the cost of the tests at a rate different than if the billing clerk had correctly identified the source of the testing, and the Respondent had "reason to know" that these claims were false as presented to SAMI. I.G. Ex 1, 67; I.G. Ex 1a, 67a; I.G. Ex 113-116; I.G. Ex 113a-116a; TR II/232, 251, 325.

48. Liability attaches under the CMPL only when the I.G. proves by a preponderance of the evidence adduced during the proceedings in a case that a respondent presented or caused to be presented false or improper claims for items or services which the respondent "knew or had reason to know" were not presented as claimed.

49. The notion that liability can only attach upon a showing of fraud or other conduct bordering on fraud is contrary to both the plain meaning of the CMPL and its legislative history; the CMPL is an administrative mechanism for deterring fraud and abuse; the CMPL applies to cases involving false or Improper claims that were filed with knowledge and intent on one end of the spectrum of liability to false or improper claims that were filed in a negligent manner on the other end (i.e., where the Respondent had "reason to know"). *See* Scott Decision and Order, pp. 25 to 27; *see also* Opinion, pp. 30 to 32.

50. The "reason to know" standard for purposes of the CMPL means that a Respondent is under a duty to investigate to ensure that false or improper claims are not being presented or caused to be presented by or for the Respondent, once the Respondent has actual notice or has sufficient information such that "a reasonable man of ordinary intelligence or one of superior intelligence" would have notice; this is where a Respondent would "either infer the existence of the fact in question or

would regard its existence as so highly probable that his conduct would be predicated upon the assumption that the fact did exist." Restatement (Second) of Torts section 12 (1965).

51. The term "reason to know," for purposes of the CMPL in this case, means that the Respondent was under a duty to investigate the claims at issue, once the Respondent had sufficient information to place a reasonable person with the superior intelligence of the Respondent in similar circumstances on notice that such an investigation would be warranted. Once the duty attached, the Respondent became liable for what a reasonable person with the superior intelligence of the Respondent in similar circumstances would have known had he investigated further. Scott, pp. 27, 28; Opinion, pp. 32, 34.

52. For purposes of the "reason to know" standard in the CMPL and Regulations, the duty to investigate is also created by a pre-existing duty of providers and practitioners to provide quality care to patients. Opinion, pp. 39, n. 15. The Respondent provided such quality care to his patients.

53. The certification on the HCFA 1500 and AMA-1 forms at issue created a duty for the Respondent to investigate the truth, accuracy and completeness of the claims submitted on those forms. This duty to investigate renders the Respondent liable under CMPL for what a reasonable person with the superior intelligence of the Respondent in similar circumstances would know had he investigated further.

54. The fact that the Medicaid rules allowed for a facsimile rubber stamp signature instead of a personal signature of the Respondent does not diminish his duty to investigate or the liability resulting from his failure to investigate.

55. The Respondent "had reason to know" of the existence and contents of the 1981 and 1982 Billing Manuals and the educational bulletins referred to in FFCL 11 to 13 or he had a duty to ensure that his billing staff read these materials carefully.

56. The Respondent (as of late 1980 or early 1981) changed his billing methodology with respect to laboratory tests for SAMI patients, and he ordered Mrs. Eby to stop paying laboratories directly. Mrs. Eby continued to seek reimbursement from SAMI and the Respondent had "reason to know" that Mrs. Eby was submitting false claims. TR III/ 544-545.

57. In an interview on July 13, 1983, Jeanette Romer stated to Mrs. Eby that there were numerous instances in which SKI had been billed by both the laboratory and by the Respondent for the same test. Mrs. Eby stated that the Respondent had instructed her on how and what he wanted her to bill. Mrs. Eby also stated that she had argued with the Respondent at times that he could not bill certain ways and things, and that she nevertheless ended up doing what the Respondent told her to do. This included billing for pan smears and the types of laboratory tests in the 418 claims at issue. I.G. Ex 422; TR III/1141.

58. Acting on behalf of the Respondent, Mrs. Eby submitted claims to the SAMI program in order to obtain reimbursement which she knew the Respondent was not entitled to. TR I/41-48, 61-63, 67, 77-79, 83-85, 89-91, 94-95, 97, 100, 105- 108, Ill, 140; TR II/284; TR III 536-538, 544, 548, 550; TR IV/609, 653; I.G. Ex 422; I.G. Ex D/2.

59. The Respondent had sufficient information with respect to the 418 claims at issue to know that further investigation was warranted, and his failure to exercise his duty to investigate those claims makes him liable under the CMPL.

60. An investigation of the 418 claims at issue by the Respondent would have revealed that such claims were for services not provided as claimed.

61. The Inspector General proved by a preponderance of the evidence that the Respondent presented or caused to be presented 418 claims containing at least 1244 items or services which he had “reason to know” were not provided as claimed.

62. Each of the 418 claims and 1244 items or services are subject to a determination under Section 101.102 of the Regulations.

63. The Inspector General proved by a preponderance of the evidence that the Respondent submitted claims for a substantial amount and for a lengthy period of time. This is an aggravating factor.

64. The Respondent’s degree of culpability is lessened because the I.G. did not prove by a preponderance of the evidence that the Respondent “knew” the claims were false. This is a mitigating circumstance.

65. The Respondent has paid $8,762.41 in restitution to the State of Nevada.

66. The same factors that are considered in determining penalties and assessments are to be considered in determining the length of a suspension. 42 C.F.R. section 1003.107.

67. The maximum civil money penalty in this case is $2,488,000 ($2,000 x 1,244 items or services claimed on the 418 claims at issue). The Inspector General proposed a penalty of $232,000.

68. The I.G. computed the assessment by doubling the amounts paid to the Respondent for 1244 items or services listed in the claims at issue in this case. See Respondent Dip 2, 3. The Regulations allow an assessment of up to double the amount claimed, a higher figure.

69. The I.G. agreed that $8,762.41 (representing the amount recouped on the claims at issue) could be subtracted from the proposed assessment. Taking this recoupment into account and taking other aggravating and mitigating circumstances into account, I have reduced the assessment to nine thousand dollars ($9,000). Nine thousand dollars is an appropriate assessment, taking into account the costs of investigating the false claims and of pursuing administrative sanctions.

70. After weighing all of the aggravating and mitigating circumstances, it is an appropriate deterrent, based on the evidence adduced in this case, to impose a penalty of $73,500 on the Respondent, and it is appropriate to suspend the Respondent from participating in the Medicaid and Medicare programs for a period of 3 years.

DISCUSSION

I find that the I.G. did not prove by a preponderance of the evidence that the Respondent had “actual knowledge” that Mrs. Eby was submitting false Medicaid claims. See, Opinion, p.28. I also find that the I.G. did not prove by a preponderance of the evidence that the Respondent conspired with Mrs. Eby to defraud Medicaid, or that the Respondent intentionally developed office procedures designed to defraud Medicaid. Instead, the preponderance of the evidence in this record supports a finding that the Respondent had “reason to know” that improper claims were being submitted on his behalf by Mrs. Eby.

I. Application of the "Reason to Know" Standard of Liability Under the CMPL and Regulations

The elements of liability for this type of case are set forth in the CMPL and Regulations.[14] With the exception of the element of scienter, the elements of liability are straightforward, need little interpretation, and are not difficult to apply.[15] I have held in prior decisions that the element of scienter, which requires a medical provider to "know" or have "reason to know" that claims presented were not provided as claimed, is not the same as intent to defraud." Scott, p. 26. Proof of actual knowledge or proof that a respondent had "reason to know" is all that the CMPL and Regulations requires for liability to attach. *See* Opinion, p. 30.

In the Scott Decision, I found that Congress in using the term "knows" and the drafters of the Regulations in using the term "knew" were referring to conscious knowledge of a fact (or subjective knowledge).[16] The term "reason to know" has a "highly specialized" meaning. Opinion page 26. It is the most difficult term in the CMPL and Regulations to apply. The application of the term in this case tests the "outer limits of the CMPL." *See* Opinion, p. 41. In analyzing the term reason to know, the Restatement(Second) of Torts (at section 12) (1965) states: "Reason to know" means that the actor has knowledge of facts from which a reasonable man of ordinary intelligence or one of the superior intelligence of the actor would either infer the

[14] For liability to be established in this case, the I.G. must prove by a preponderance of the evidence that: (I) the Respondent (a "person") (2) "presented or caused to be presented" (3) the Medicaid "claims" in issue (4) to the SAMI program ("agency") (5) for medical (laboratory) "items or services" when, in fact, (6) reimbursable laboratory services were "not provided as claimed" and (7) the Respondent "knew or had reason to know" that the laboratory services were not provided as claimed. *See* Scott, at pages 26 to 28.

[15] The CMPL and Regulations contain slightly different language with identical meaning. Under section 1320 a-7a(l)(a) of the CMPL, liability attaches when: "the person knows or has reason to know." Under section 1003.102 (a) (1) of the Regulations, liability attaches when "the person knew or had reason to know."

[16] It should be noted that proof of actual knowledge is considered to be an aggravating factor. Regulations Section 1003.106(b)(2).107.

existence of the fact in question or would regard its existence as so highly probable that his conduct would be predicated upon the assumption that the fact did exist.

Thus, "reason to know" employs the "reasonable person" (objective knowledge) concept. *See also* Restatement (Second) of Agency, section 9 (1957). In discussing objective knowledge, Professor Keeton, in Keeton and Prosser on Torts, states that one of the most difficult questions (in connection with negligence) "is that of what the actor may be required to know."[17]

In Fidler v. Eastman Kodak Co., 555 F. Supp. 87, 92 (D. Mass. 1982), the term "reason to know" was analyzed. The Court cited the Restatement (Second) of Torts and stated that: Alternatively, the actor would regard the existence of the particular fact in question as so legally probable that he would base his conduct upon the assumption that the fact existed. The Court then concluded:

Mrs. Fidler was in possession of information from which a reasonable person would have inferred the fact of causation. Accordingly, her conduct should have been governed by the assumption that such fact of causation existed. Therefore, she had reason to know the cause of her physical damage, and cannot be excused for her failure to file suit in a timely fashion. The "reason to know" standard does not create a duty on the part of a respondent to ferret out false or improper claims presented by an employee unless (1) the respondent has sufficient information to place him, as a reasonable medical provider, on notice that the claims presented were for services not provided as claimed, or (2) there are pre-existing duties created which would require a respondent to verify the truth, accuracy, and completeness of claims presented or caused to be presented to Medicaid or Medicare. *See* Scott, pp. 25 to 30; Opinion, p. 32.

Thus, if the Respondent in this case acted negligently in light of information that came to his attention or if he ignored pre-existing requirements or duties, such as a Medicaid requirement to examine the claims at issue before they were presented to

[17] For a discussion of subjective knowledge and objective knowledge, see Seavy, "Negligence-Subjective or Objective," 41 Harv. L. Rev. 1, 17. *See also* Restatement (Second) of Torts, sections 289, 290; Opinion, p. 28.

Medicaid, he would be liable under the CMPL for the false or improper claims filed at issue in this case.

In analyzing the breadth and scope of the phrase "knows or has reason to know," I am guided by the preamble to the Regulations, which declares: "The statute sweeps within its ambit not only the knowing, but the negligent. . . ." 48 Fed. Reg. 38827, 38831 (Aug. 26, 1983). From this, and from analyzing the CMPL and Regulations, I conclude (as I did in the Scott case) that the phrase "knows or has reason to know" encompasses a spectrum where liability attaches on one end of the spectrum when a respondent files false claims with actual knowledge and attaches on the other end of the spectrum when a respondent files false or improper claims in a negligent manner. The Deputy Under Secretary's Opinion (at pages 30 to 32) affirms this analysis. To determine whether the Respondent acted negligently for purposes of liability under the CMPL and Regulations, I must determine whether there is enough evidence in this record which proves that the Respondent did not act as a "reasonable person." Opinion, p. 34. To analyze the "reasonable person" standard for purposes of the CMPL, I must first make the judgment as to whether sufficient information came to the Respondent's attention to spring into existence the duty to investigate the accuracy of the claims and then make a judgment as to what the results would show if he had investigated. Opinion, p. 32. In applying this standard, I must determine whether to consider the Respondent's actions in relation to a person of "ordinary" intelligence or to take into account evidence "of the superior intelligence of the actor." *See* Restatement (Second) of Torts, section 12. I agree with the I.G. that the Respondent should be judged in terms of the highly educated, board certified, and highly successful physician that he is. *See* I.G. Rem Br/4, 5. I must also determine whether any pre-existing duties exist in this case so as to vitiate the need for "independent proof to cause the duty to spring into existence." Opinion, p. 39, n. 15.

II. Rules, Procedures and Regulations Governing the Submission and Processing of the Medicaid Claims at Issue

At all times relevant to this case, SAMI issued Billing Manuals and Medicaid Bulletins to participating providers at the provider's billing address, and operated a provider services department. These were designed to ensure compliance with the Medicaid regulations and to assist providers in billing. I.G. Stip. B 5; I.G. Ex 426, I.G. Ex F.; TR III/550. Billing Manuals were distributed to all providers in Nevada in 1981 and 1982. TR I/143, 146; TR II/215, 216. The Respondent received

these Billing Manuals and the Medicaid Bulletins. TR I/100; TR II/216; I.G. Ex 426.

Mrs. Eby, the Respondent's billing clerk, would place these publications on the Respondent's desk. TR I/100. During the dates at issue in this case, BSN's provider services representatives were employed to personally visit providers, answer questions via a toll-free telephone line maintained for the providers, and conduct workshops for training providers or their staff in proper billing of Medicaid. TR II/212, 213. The Respondent was required to identify each claimed service by using a specific procedure code. Procedure codes are set forth in the 1974 California Relative Value Studies (CRVS) Manual. FFCL/30, 31, 33; I. G. Ex 431; TR II/286, 290. The rules, regulation, and directions for use of the proper procedure codes are set forth in the Billing Manual, the Medicaid Bulletins, and the 1974 CRVS manual. The pathology section of the 1974 CVRS manual governs the submission of claims for laboratory test services. FFCL/30, 31, 33; I.G. Ex 426, 431; TR II/217. These publications establish the items and services for which providers may seek payment and specify instances in which payment is improper or an abuse of the Medicaid program. FFCL/31, 32; I.G. Ex 426/15.

The process of collecting and handling laboratory test specimens (handling fees) is identified by a specific procedure code number set forth in the 1974 CVRS procedure codes. The procedure codes used for lab tests performed on the specimens are different from the procedure codes for collecting and handling the specimens. FFCL/34, 36. The CRVS manual sets forth a simple rule for collecting and handling a laboratory test specimen: if a patient is seen by a physician solely for the collection of a specimen and no other service is provided and billed, the physician may bill a handling fee for each specimen collected by using procedure code 99007. FFCL/38; I.G. Ex 431/4, section 9; TR I/81 171-172, TR II/256, 287-288. If, in addition to collecting specimens, the physician provides and bills other services (e.g., an office visit), he may not bill for a handling fee, except for the service of drawing blood. FFCL/38; TR 2/168, TR II/255-256, 288.

The 1974 CRVS manual instructions on billing for the handling of test specimens have been in effect since 1974 and are the exclusive rules applied by the SAMI program. FFCL/30, 31, 33; TR II/217-218, 290. If a provider sought payment for both an office visit or physical examination and payment for the collection of a specimen, the handling fee was not allowable (except for the

drawing of blood) and the submission of such a claim was and is an abuse of the Medicaid program. FFCL/32; TR II/254-256; I.G. Ex B. The Respondent's claims at issue in this case did not show the handling fee procedure codes, but rather procedure codes for the lab tests themselves. The Nevada Medicaid program required that claims for payment or reimbursement be submitted on designated claims forms (the HCFA-1500 or the AMA-1) and contain specified information. I.G. Ex 426 at 5; I.G. Ex F. The provider was required to sign the claim at the bottom of the form. The signature constituted a certification that the information on the claim was true, accurate, and complete and an acknowledgment that any false claims, statements or concealment of material facts were subject to prosecution under federal or state law. I.G. 426/8. The certification statement is present on all but 12 of the 418 claims at issue. FFCL/16.

If the medical provider was reimbursing the labs for tests performed and seeking payment from Medicaid, the provider had to indicate the date and place of service, describe the service (by using 1974 CRVS procedure code number and written description), enter the name and address of the lab, and the amount the Respondent paid to the lab. I. G. Ex 426. The Medicaid program allowed providers to bill Medicaid directly for the lab tests performed by an outside laboratory only when the providers paid the lab and billed SAMI for reimbursement. I.G. Ex 426/10; I.G. Ex F/2; TR II/253. If lab work was done in the provider's office, it was not payable by SAMI unless the physician's laboratory was certified by the Nevada Bureau of Laboratories and Research. FFCL/42; I.G. Ex F/2; I.G. Ex 426/9-10; TR I/128, 151-152.

After reviewing a claim for correct procedure codes, completeness, amount to be paid for any laboratory services, and disallowing non-covered services (TR III/502, II/265), a BSN claims processor brought the claim up on his or her computer terminal screen to clear it for payment.[18] During the period at

[18] At all times relevant to this case, all Medicaid claims for payment sent to SAMI were assigned by BSN to a claims processor; the assignment was based on the type of provider submitting the claim. TR I/24; TR II/246 to 298. The claims processor reviewed each line item on each claim to determine if the claim was payable and, if so, at what amount. TR II/265. If laboratory work was claimed, box 22 of the form (I.G. Ex 426/7) was reviewed to see whether the tests were performed in the physician's office or sent to a reference lab. TR II/248. If the physician indicated that the lab work was sent to an outside

issue, the BSN computer did not detect any errors in the Respondent's claims. The computer was apparently not programmed to alert the claims processor to a potential duplicate billing from a physician and a laboratory. TR II/226, 261, 267; TR IV/667, 689.

If a claim was to be paid after review by the claims processor, it was forwarded to the payment branch at BSN for issuance of a check to the provider. The provider was then given "explanation of benefits" forms (EOB's) which detailed what services were payable, and how much was payable, and listed reasons why payment for items or services had been denied. TR I/40-41, 48, 90, 94. If there were any questions or confusion about the proper procedure codes to use, what was properly payable by Medicaid or what constituted abuse of the Medicaid program, the provider or his billing staff could have, and had the responsibility to, request more detailed explanations; BSN's provider services department was always available to answer questions. TR II/ 213, 214-215; I.G. Ex 426/15 to 17.

III. The Submission of the Improper Claims at Issue

The Respondent employed Mrs. Kathleen Eby as his billing clerk from 1973 to date. I.G. Stip/B6; TR I/38,39, 44; TR IV/531, 532, 549. During the period at issue, the Respondent delegated to Mrs. Eby the responsibility of preparing Medicaid claims for submission to the SAMI program and signing the SAMI claims on his behalf without the Respondent's review. TR I/43, 47-48, 108; See R Rep Br/17. When SAMI forwarded payments to the Respondent's office along with explanation of benefits forms

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laboratory, the claims examiner reviewed box 21 of the form to determine which laboratory rendered the service. The price list for that laboratory was referred to and the charge for the particular test was noted on the claim. TR II/213-232, 248-250. Where the cost of a test exceeded the maximum amount allowed by the program, the test was priced at the allowable maximum. TR II/251-252. If the physician misidentified the laboratory rendering the test, the wrong price list would have been used to calculate payment to the physician. TR II/232, 251. BSN did not require the provider to submit the invoice from the outside laboratory for tests performed. FFCL/32; TR II/244. Similarly, the provider was not required to indicate in box 22 of the claim form the cumulative charges for laboratory services (TR II/225, 262-263), but all charges had to be itemized in box 24. Column E of box 24 was the only relevant price information needed for the processing of the claim. TR II/225, 262-263, TR IV/443.

(EOB's), Mrs Eby noted on each patient's billing ledger the amount paid for each service claimed. TR I/40, 1150. In instances where SAMI or BSN did not pay, Mrs. Eby often contacted the BSN provider service department and requested an explanation of the EOB's. TR I/41. On rare occasions, the Respondent personally reviewed the EOB's and discussed SAMI billing with Mrs. Eby. TR I/48-49, 61.

During the period at issue, the Respondent relied on commercial laboratories to perform the analysis of specimens obtained from his patients (e.g., pap smears, vaginal and urine cultures, urinalysis and blood tests). TR I/49, 64, 74; TR III/519. The Respondent's nurse would review a patient's medical chart and complete a test requisition form indicating the lab tests that were ordered by the Respondent; these tests were performed by an outside lab. TR IV/524. The laboratory, when notified, sent a courier to pie up the specimens and the requisition forms. TR II/299. Upon arrival at the laboratory, the specimens were logged into a computer and assigned an identification number before the requested lab tests were performed. TR III/301. The test results were then reviewed by the Respondent's office personnel. If the results were normal, the test results were placed on the patient's medical chart without the Respondent's review. If the results were abnormal, they would be shown to the Respondent. TR III/524. This procedure saved the Respondent the effort of reviewing all of the lab results. TR III/525. Whenever the Respondent was not shown a patient's test results, he assumed the results were normal. TR III/524. Because most of his patients were "generally infected" and had "obvious kinds of things going on," the Respondent prescribed medications at the same time that the test specimens were taken. TR III/516, 524. If the patient was not heard from, the Respondent assumed that she had gotten better. TR III/524.

From about 1973 until about 1978, the Respondent performed all routine lab tests in his own office using a certified lab technician. I.G. Ex 425/I. The Respondent's lab was not certified as required by Nevada law. TR I/58, 128, 130, 152, TR III/530, 540; I.G. Ex 421. During this period, Mrs. Eby would indicate on item 22 of the Medicaid claim form (see I.G. 426/7) that laboratory work was not performed outside of the office. TR I/72.

From 1978 to early 1981, the Respondent paid outside labs for performing his lab tests. I.G. Ex D. The Respondent began to rely on commercial laboratories because, in 1977, he was informed that his lab was uncertified and that Medicaid would

not pay for lab tests performed by an uncertified lab. The Respondent's SAMI claim form submitted during this period indicated that an outside laboratory had performed the test; item 21 indicated the name and address of the laboratory for the tests done. TR I/61, 64-65, 74.

Some time in late 1980 or in early 1981, Mrs. Eby claimed handling fees for lab tests by using the correct 1974 CRVS codes for handling fees. Mrs. Eby testified that she began to claim handling fees in 1980 or 1981 for handling laboratory specimens because she had been ignorant of handling fees before that time. TR I/74, 78, 79, 82, 92. The provider services department at BSN gave her instructions on how to claim the fees. BSN told Mrs. Eby which 1974 CRVS codes were to be used on the claim forms. TR I/79-81. She was told that SAMI would pay only a set price for the handling fees. TR I/ 78,82.[19]

Despite Mrs. Eby's contact with BSN about how to properly bill for handling fees; Mrs. Eby claimed handling fees for things for which Medicaid did not allow (i.e., urine cultures, urinalysis, pap smears and vaginal cultures when there was an office visit). I.G. Ex B; TR I/89-93.[20] Soon after Mrs. Eby began to claim these handling fees, a claims processor denied the handling fees to the Respondent, noted the denial on the claim form and instructed the computer not to pay that portion of the claim. I.G. Ex B; TR II/254-256. Each improperly claimed handling fee was itemized and the basis for the denial of payment was noted on EOB's and forwarded to the Respondent. I.G. Ex B-l; TR I/40-41, 90 to 91, 94 to 95.

During the period at issue in this case, August 13, 1981 through April 11, 1983, the Respondent stopped reimbursing test laboratories and, instead, let the lab bill the SAMI program directly. TR I/61, III/544; *see* I.G. Ex D/7. Once he adopted this procedure, the Respondent was not permitted by the Medicaid rules and regulations to bill SAMI separately for the performance of any laboratory tests or for handling fees. TR

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[19] This same information was already available to Mrs. Eby in the 1981 Medicaid Billing Manual (I.G. Ex 426), the October 1980 SAMI Bulletin relating to billing requirements (I.G. Ex F), and during the annual training workshops sponsored by BSN. TR I/100-101; II/213.

[20] Because the specimens had been collected as a part of a physical examination of the patient, their collection and handling were not payable by the SAMI program.

I/143, 148-149; I.G. Ex 426/9.

Despite this, Mrs. Eby filed claims for laboratory tests. The claims submitted during this period appear to be identical to the claims submitted by Mrs. Eby during that period when the Respondent had been paying the outside labs, except that these claims did not specify the cost of the test. Opinion, pages 6,7. Mrs. Eby's procedures for billing laboratory services to the SAMI program were as follows: A list of services provided to a Medicaid patient was recorded on a billing ledger by the office receptionist after she reviewed the patient's medical chart. TR I/44-45, 70. Mrs. Eby then would refer to the billing ledger in order to complete the SAMI claim form. TR I/140; II/284. Any laboratory work listed on the billing ledger would be included specifically on the SAMI claim. TR I/44-70. The SAMI claims for laboratory tests were submitted to BSN be fore the test results were received by the Respondent's office. TR I/45, 66-67, 284. When the test results arrived at the Respondent's office, Mrs. Eby would check to make sure that all the tests for which payment had been claimed were performed and that the results were noted properly on the patients' charts by the "girls in the front office." TR I/46-47, 58. Mrs. Eby explained that the Respondent reviewed the lab test results when they were received and rarely noted that the result of a test he had ordered was not in a patient's chart. TR 2/47, 48, 58.

It is significant to note that Mrs. Eby conceded that the claims filed during the period at issue looked identical to the claims filed for the period when the Respondent paid the labs directly and then sought reimbursement from SAMI (i.e., the second period). TR 2/78. This is the period immediately following the notification that Medicaid would not pay for handling fees for lab tests (when there was an office visit) for urine culture, pap smears, urinalysis, and vaginal cultures. Thus, the Respondent was put on notice and Mrs. Eby knew very well that any attempt to bill Medicaid for handling fees for urine cultures, urinalysis, vaginal cultures, and pap smears when she also billed for an office visit was an abuse of the Medicaid program. Since the claims submitted during the period at issue looked almost identical to the claims submitted when the Respondent paid the labs and sought reimbursement from SAMI, I find that Mrs. Eby sought to create the impression to SAMI that

the Respondent was seeking reimbursement for lab fees and not for handling fees.[21]

The Respondent profited by the amount of $9,204.38 from this practice until October of 1983, when the Nevada Medicaid program switched to a sole source laboratory contract, under which two designated laboratories performed all the testing for the SAMI program and billed SAMI directly. TR I/190-191; TR II/275- 276.

IV. The State and Federal Investigations of the Respondent's Medicaid Billing Practices

NHDR is responsible for investigating allegations of fraud or the filing of false claims by providers in the SAMI program. In October of 1982, BSN notified the NHDR that the Respondent was submitting claims for lab services that were performed by outside labs and billed by the labs directly to SAMI. TR I/127. NDHR then commenced an investigation. TR I/126. NDHR did not communicate with the Respondent until May 2, 1983, when it requested that the Respondent make available certain of his records. TR I/131.

Jeanette Romer, an investigator for NHDR, opened the investigation. I.G. Ex 420. Ms. Romer compiled a list of patient names and laboratory tests billed on their behalf for the period from 1979 through 1983. TR I/131. Ms. Romer concluded that on numerous occasions the same test had been billed twice. TR I/131, 132. In July of 1983, Ms. Romer and Ms. Molly Earnhart, a medical review specialist with NHDR, conducted a week-long record search at the Respondent's medical office. TR I/133; TR

[21] The Respondent's argument that BSN should have been able to detect the fact that the Respondent was not seeking reimbursement for the lab tests themselves is not supported by the evidence in this case. Quite the contrary, the carrier, BSN, would not have been able to spot the claims in issue as improper claims on their face. Mrs. Eby purposely listed the 1974 CRVS procedure/codes for the tests themselves and identified an outside laboratory as the facility performing the tests. TR I/77-78. In all the claims in issue, she identified the tests themselves rather than describe the item as a handling fee. As a result of this, BSN claims processors reviewing these claims paid the Respondent for the cost of these tests thinking that the outside lab identified was being reimbursed by the Respondent. TR II/253. In reality, the Respondent was not paying the outside lab and the lab was billing the SAMI program directly. TR I/61, 151.

II/281. As part of the review, the investigators pulled the chart of each patient on the billing list and reviewed all test-related documentation. TR I/133; II/282. At the end of her audit, Ms. Romer found that most of the Respondent's charts did not have laboratory results for any urinalysis tests, although they had been ordered. TR 134, 184-185. Ms. Romer also found that the test results frequently billed by the Respondent, such as urinend vaginal cultures, pap smears and complete blood counts, were also missing from the patient's medical charts. TR I/134-135.

At this time, Ms. Romer and Ms. Earnhart interviewed Mrs. Eby concerning the Respondent's billing practices; Mrs. Eby explained that she had told the Respondent that he could not bill for certain things, but that he would not believe her. TR I/141; I.G. Ex 422. At that time, Mrs. Eby made no suggestion that she was attempting to collect handling fees through the misidentification of the 1974 CRVS codes. TR I/141; II/283. Ms. Romer concluded that the claims she viewed were false and she recommended that the State proceed to exclude the Respondent from participation in the Medicaid program. TR I/154, 174, 187; I.G. Ex 420. Her conclusions were there were a number of false claims (submitted from 1981 to 1983) in addition to the claims at issue here. R Ex 6/169, 178; TR I/92.

After the NHDR completed its investigation of the Respondent, it referred the case to the DHHS for possible prosecution under the CMPL. TR I/157. Ms. Romer worked on the federal investigation; she contacted two laboratories where the Respondent referred lab test specimens during 1983. During the initial analysis of the Respondent's laboratory billings, it had been noted that while the Respondent and the laboratory usually billed for the identical tests, in a number of instances only the Respondent had billed for a urinalysis test. TR I/ 157. Because this raised a question whether the urinalysis had been performed by the laboratory, Ms. Romer wrote the two laboratories (National Health Laboratories (NHL) and Associated Pathologists Laboratories (APL)) and requested lab reports for some of the Respondent's patients. TR I/158, 160; *see* I.G. Ex 427, I.G. Ex 430. The general manager of NHL, Joseph Stone, reviewed the laboratory's report files for the requested tests and was unable to find any test results corresponding to Ms. Romer's list. I.G. Ex 430; TR I/161. By law, APL keeps copies of all the requisition slips submitted by physicians for a period of five years. TR III/303. The requisition slip indicates the tests that have been requested and, in addition, reflects any complaints from the physician that tests were not performed as requested.

TR III/302-303. In 66 of the 69 instances where the Respondent billed the SAMI program for the performance of a urinalysis test, no urinalysis had been requested by the Respondent nor had the test been performed by APL. TR II/164-166; I.G. Ex 1(B)-67(b).

A second review of the Respondent's medical records was performed as part of the federal investigation by Al Montano, an investigator for the I.G. The results of Mr. Montano's analysis (I.G. Ex G) confirmed that the Respondent routinely billed Medicaid for urinalysis testing which was never performed (TR I/184-185; TR IV/596), and that the Respondent had billed SAMI for other tests (such as pap smears, vaginal cultures and blood tests) where the patient's chart did not contain a test result and the laboratory had not billed for the test. TR II/322-323, 325-326, 345-346. Also, the claims submitted misrepresented which laboratories actually performed the tests. TR II/325. Based on the federal and State findings, the I.G. formally notified the Respondent on August 2, 1985 of his proposed imposition against the Respondent of a penalty, an assessment and a suspension from the Medicaid and Medicare programs.

The above evidences that the Respondent's medical records were kept in a negligent manner. While there is no evidence that the Respondent's sloppy record keeping affected the quality of medical care rendered to Medicaid patients, an inference can be drawn that it could have.

V. The Evidence in the Record Establishes that the Respondent's Billing Clerk, Mrs. Eby, Submitted the Improper Claims at Issue Because of Interference or Pressure Exerts by the Respondent

Each of the 418 claims forms at issue identifies a commercial laboratory as the source of laboratory testing, itemizes the cost of each test, and has the signature of "Frank P. Silver, M.D." in the signature block, certifying that the services were rendered as claimed. The Respondent and Mrs. Eby admitted that the commercial laboratories had not been paid by the Respondent to perform the tests in question. TR I/77; TR III/541. Each of the 1,244 services listed on the 418 claims at issue where the Respondent claimed reimbursement from Medicaid for the cost of a laboratory test is an improper claim, and I conclude that Mrs. Eby purposely filed these claims knowing that they were false.

Each of the claims are false because they represented that the Respondent had reimbursed commercial laboratories for the performance of between one and six lab tests when, in fact, the

services were not performed as claimed because the laboratories had not been reimbursed for such testing services by the Respondent. In at least 91 instances, the claims indicated that laboratory tests had been performed by a laboratory when, in fact, the tests had not been performed at all. In addition, in 71 of the claims at issue, the commercial laboratory performing the itemized tests had been misidentified. There was absolutely no need for the submission of claims for lab tests because the laboratories were billing Medicaid directly and because the Respondent had chosen not to reimburse the commercial labs for the tests.

After reviewing the entire record, including the testimony of all the witnesses in this case, I find the testimony of Jeanette Romer, Molly Earnhart, Alfonso Montano, and of the other I.G. witnesses to be credible and reliable.

I find Mrs. Eby's hearing testimony to be unreliable. Her testimony is inconsistent with the facts established by the testimony of others and the exhibits in the record, especially the testimony of Jeanette Romer. The Deputy Under Secretary's Opinion finds that the record amply reflects the fact that Mrs. Eby acted recklessly at best and with a "touch of larceny," at worst. *See* Opinion, p. 16. Mrs. Eby testified that she did not comply with the Medicaid rules and regulations because she did not have a copy of the SKI Billing Manual and did not see pertinent Medicaid Bulletins. TR I/103, 104, 113 to 115, 122; I.G. Ex D, F, 426. Mrs. Eby testified: "I never intentionally billed to fraud anybody. My error here is my own stupid error in not knowing what I was doing, as far as coding is concerned." *Id.* She, in essence, claims to have sought handling fees for the lab tests and through error submitted claims for the tests themselves. The evidence demonstrates that this is not true.

The evidence shows that Mrs. Eby was not confused about handling fees at all; she knew that the Respondent would not be paid for them by SAMI if she used the proper 1974 CRVS procedure codes for handling fees because Medicaid had told her that the Respondent could not get handling fees for the lab tests at issue. To overcome that obstacle, Mrs. Eby intentionally deceived Medicaid by using the wrong procedure codes. Mrs. Eby has worked full-time as a medical billing clerk and office manager since 1973 and during that time submitted SAMI claims for three different physicians. TR I/38, 39, 104. As providers, the three physicians were sent copies of the SAMI Billing Manual as well as SAMI Bulletins. TR I/115, II/215-216. Mrs. Eby admitted that she questioned the billing staff at other

physicians' offices about processing SAMI claims, yet she stated that she never was told by these persons of the existence of the SAMI Billing Manual that addressed the very questions she asked about. *See* TR I/83. She admits to having attended two of the annual billing workshops sponsored by BSN, yet she stated that she never saw the Medicaid Billing Manual and SAMI Bulletins made available to all the participants. TR II/213.

Despite her denials, the evidence indicates that Mrs. Eby had frequent telephone and other contacts with BSN personnel. TR I/41, 78, 79, 96, 112. She stated that she did not, to her knowledge, ever contact BSN by telephone. TR I/41. Mrs. Eby stated that she often contacted BSN by mail. TR I/95, 96. Ms. La Fleur testified that she received regular telephone inquiries from Mrs. Eby and that she kept Dr. Silver's office telephone number available in the event she could not answer Mrs. Eby's questions immediately; I find Ms. La Fleur's testimony to be credible. *See* TR II/218-222. Ms. La Fleur's testimony demonstrates that Mrs. Eby was not forthright and truthful. Also, although Mrs. Eby denied ever meeting with a field representative from BSN in 1982 (TR I/99), the Respondent stated that Mrs. Eby had been contacted by a Medicaid representative who answered her questions (TR III/550-551).

I find Mrs. Eby's claim of ignorance not believable, especially considering that Mrs. Eby was submitting claims, reviewing EOB's, and questioning denials of payment for over thirteen years. TR I/38 to 39, 104 to 105, 115. Anyone in her position would have a good understanding of the SAMI program and its billing requirements. See, TR III/387. The Respondent's own witness, William Bennett, stated, in effect, that it was Mrs. Eby's responsibility to have copies of the SAMI Billing Manual and the Medicaid Bulletins. TR II/385 to 389. I find that, despite her denials, Mrs. Eby knew of the SAMI Billing Manual, the pertinent Medicaid Bulletins, their contents, and how to file Medicaid claims properly.

The record amply reflects the fact that Mrs. Eby knew exactly what she was doing. First, in 1981, despite Mrs. Eby's contact with BSN about how to properly bill for handling fees, Mrs. Eby claimed handling fees for urine cultures, urinalysis, pap smears and vaginal cultures when there was an office visit. I.G. Ex B; TR I/89-93. In 1981, soon after Mrs. Eby began to claim these handling fees, a claims processor denied the handling fees to the Respondent, noted the denial on the claim form, and instructed the computer not to pay that portion of the claim. I.G. Ex B; TR II/254-256. Each improperly claimed handling fee

was itemized and the basis for the denial of payment was noted on EOB's. I.G. Ex B/1; TR I/40-41, 90-91, 94-95. In spite of this, Mrs. Eby claimed ignorance at the hearing. Second, I give great weight to a July 13, 1983 memorandum of interview between Medicaid investigators (Jeanette Romer and Molly Earnhart) and Mrs. Eby. I.G. Ex 422. This "Memorandum of Interview" solves the mystery of how an experienced billing clerk such as Mrs. Eby submitted false claims. She did it because even though she "argued with" the Respondent about billing Medicaid, the Respondent "instructed her on how and what he wanted her to bill," and she "still ended up doing what Dr. Silver wanted her to do." I.G. Ex 422. I find these statements made by Mrs. Eby to the State investigators in 1983 to be more reliable than her hearing testimony. This evidence makes it clear that Dr. Silver interfered with Mrs. Eby's Medicaid billing and that this interference led to the submission of the false claims at issue.

Further evidence of the Respondent's interference is the statement "prepared by Jeanette Romer, at the request of Mrs. Eby in 1983, on Dr. Silver's stationery. Mrs. Eby asked Ms. Romer to verify in writing that SAMI would not pay for pap smear handling fees when an examination was performed. Even though this was done after the claims at issue were submitted, I find that this was done because Dr. Silver had a habit of not believing Mrs. Eby and of telling her to file Medicaid claims incorrectly because he did not believe her. *See* I.G. Ex 423.

The record suggests that it was Dr. Silver's arrogant attitude in not believing Mrs. Eby when she told him that Medicaid would not accept claims for laboratory handling fees that got him into trouble, and not her alleged ignorance. I find that the I.G. proved by a preponderance of the evidence that Mrs. Eby told the Respondent that it was improper to submit claims for laboratory handling fees to Medicaid (like the claims at issue), and that the Respondent chose to ignore her, thinking that he knew better than she.

By interfering with the trained professional that he hired to file claims for him, the Respondent was so negligent in his responsibility to the Medicaid program as to give rise to a duty to investigate whether the claims submitted by Mrs. Eby were proper claims. He insisted that the billing clerk place a higher priority on his instructions than on instructions from Medicaid. By doing this, he assumed the burden of ensuring that his instructions and the consequent claims were accurate and lawful.

VI. The Evidence in the Record Establishes That the Respondent Had "Reason to Know" that His Billing Clerk, Mrs. Eby, Was Submitting the Medicaid Claims at Issue for Services That Were Not Provided as Claimed

I find that the I.G. proved by a preponderance of the evidence that the Respondent had sufficient information from which a reasonable medical provider in his circumstances had "reason to now" that further investigation of Mrs. Eby's billing practices was warranted. *See* Opinion, p. 9, 16.[22] I find and conclude that the Respondent had "reason to know" that the claims at issue in this case were false claims because: (l) the Respondent had a duty to Medicaid to verify the truth, accuracy and completeness of the claims he caused to be presented; (2) the record in this case establishes that the Respondent was negligent (in light of sufficient information which put the Respondent, as a reasonable medical provider, on notice that he should investigate Mrs. Eby's billing activities); (3) the Respondent interfered with Mrs. Eby's Medicaid billing function by putting pressure on her to file Medicaid claims his way without familiarizing himself with the Medicaid regulations; (4) the Respondent made a drastic change in his financial relationship with commercial laboratories just prior to the period at issue which eliminated the basis for filing any Medicaid claims for lab tests or handling fees; and (5) a cursory examination of the claims by the Respondent would have revealed that they were false or improper. *See* Opinion, p. 15, 39.

A. The Respondent Was Under a Duty to Investigate the Truth, Accuracy and Completeness of 406 of the Claims at Issue Before They Were Submitted, by Virtue of the Certification Statements on Those Claims

The Deputy Under Secretary's Opinion states that the duty to investigate the propriety of claims being submitted to Medicaid may be triggered by pre-existing duties on the part of medical

[22] I find that Dr. Silver's testimony did not rebut the I.G.'s proof that he had "reason to know" because he was not as candid as he could have been about: (1) his working relationship with Mrs. Eby; (2) the attitude he displayed towards her concerning her handling of the billing function; (3) Mrs. Eby's remarks to him about what Medicaid would not pay for; (4) arguments he had with Mrs. Eby about the proper way to submit claims to Medicaid; and (5) his interference with her activities which led to the submission of the false claims. *See* TR III/539 to 551.

providers. The Opinion cites as an example the duty of care owed by a medical provider to each of his patients. *See* Opinion, p. 39. The Opinion states that a pre-existing duty vitiates the requirement for independent proof to cause the duty to investigate to spring into existence. A pre-existing duty is created by proof of a certification statement on 406 of the claims at issue in this case; this duty is similar to the duty of quality care. Whether it creates a pre-existing duty or not, it does, at the very least, cause a duty to investigate to spring into existence under the "reason to know" standard of liability in the CMPL and Regulations. See Opinion, p. 26.[23] The certification on these Medicaid claims reads "NOTICE: This is to certify that the foregoing information is true, accurate and complete." *See* I.G. Ex 426/8; P; Q. This statement is required to appear on all Medicaid claim forms pursuant to 42 C.F.R. Section 455.18.

The certification statement was a representation by the Respondent that he had acquired sufficient information to assure the Medicaid program that the claims were true, correct and complete. The Respondent was required to sign or at least initial the claims. He chose to authorize his billing clerk to use a signature stamp. There is no evidence that the Respondent was unaware of the certification requirement; in fact, he obviously knew that the claims were required to bear his signature because he had the signature stamp prepared. The certification statement created a duty on the Respondent to investigate the accuracy of claims bearing a certification. Certifications similar to the claims at issue are familiar to many government claim forms. In complex systems like Medicaid, it is quite common for persons to attempt to shift responsibility for false claims to others. Those administering the program attempt to affix personal responsibility for claim information on the medical provider.

While the Respondent was allowed to use a facsimile stamp for his signature, he was required to initial each claim form after

[23] Exhibit P is an affidavit from Jeanette Romer, which states that 341 of the 418 claims in issue were submitted on complete (front and reverse) HCFA 1500 forms, and an additional 65 claims were submitted on complete (front and reverse) AMA-1 forms. Both of these kinds of forms contain the certification statement cited above. I.G. Ex 426/8; P; Q.

he checked the accuracy of each claim.[24] The Medicaid program in Nevada allows facsimile stamps to be used as a convenience to providers, so that providers will not have to sign hundreds to claim forms. S.C. Ex. 426/9. At the same time, the certification of true accuracy and completeness is a common means of gaining some reasonable assurance that the provider has assured that the claims are indeed true, accurate and complete.[25]

The use of certification statements to create a certain representation by a medical provider was discussed in U.S. ex rel. Fahner v. Alaska, 591 F. Supp 794 (N.D. Ill., 1984). In that case, claims by an optometrist to the Medicaid program of Illinois contained certification language virtually identical to the case at bar: "This is to certify that the information above is true, accurate and complete. . ." 591 F. Supp. at 796. In Peterson v. Weinberger, 508 F.2d 45, 52 (5th Cir.); *cert. denied*, 423 U.S. 830 (1975), Medicare claims for nursing home services stated: "A physician's signature certifies that physician services were personally rendered by him or under his personal direction." The Court commented:

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[24]There is some evidence that a billing clerk's signature or initials (when a facsimile stamp is used) is not acceptable to Medicaid. The heading of the signature blocks on these forms call for "SIGNATURE OF PHYSICIAN OR SUPPLIER." The billing manual states that a "Provider's signature or facsimile stamp (initialed) must be on every claim and every page of each claim." S.C. Ex. 426/9. However, the SAMI program accepted the claims at issue with the initials of Mrs. Eby (KE) next to the signature stamp of the Respondent. The proof in the record demonstrates that the Medicaid program would not pay on the signature of Kathleen Eby.

[25] The Respondent confuses the Medicare certification language with the Medicaid certification language on the HCFA 1500 form. These certifications are quite different and are tailored to the requirements of the specific programs. The Medicare certification language does not apply to Medicaid claims. Also, the decision cited by Respondent with respect to facsimile stamps, Snell v. Comm. of Penn. St. Ex. Bait., 416 A. 2d 468 (Pa. 1980), has no application to the case at bar. Snell concerned the issues of whether findings of actual knowledge of wrongdoing or intent to defraud could be derived from a claim submitted with a facsimile stamp. These issues are completely distinct from a "reason to know" standard.

It was entirely reasonable and necessary for the Government to require such a certification on the claim forms to implement the Act, and at the same time protect public funds. Obviously, a false certification on the claim form frustrated the Government's attempt to process only valid claims and led to the payment for services which were not covered or payable under the Act.

Here, the Respondent, under a certification of truth, accuracy and completeness of the claims, was under a duty to investigate the truth, accuracy and completeness of these claims.[26] The certification statements in this case were reasonable means to notify the provider of a personal responsibility to ensure the accuracy of all claims. A duty to ensure accuracy is created by the inclusion of the statement as part of the application. Whether the Respondent personally signed the statement is not relevant. Even if the Respondent did not have actual knowledge of a particular claim, he was aware of his general duty to ensure the accuracy of all claims submitted for him. At the very least, this responsibility causes the duty to investigate to spring into existence for purposes of the "reason to know" standard.

B. The Respondent Had "Reason to Know" Mrs. Eby was Filing False Claims Because a Reasonable Medical Provider Would Have Reason to Know Through Reasonable Supervision and Attentiveness

I find that the Respondent had sufficient notice that Mrs. Eby was filing false or improper Medicaid claims so as to spring his duty to investigate into existence. *See* Opinion, p. 32. As I discuss above, a mere glance at the 418 claims at issue would have revealed to the Respondent that they were false.

The Respondent's failure to perform his duty to investigate in light of notice makes him liable for the claims at issue under the CMPL and Regulations. If this factor is coupled with the fact that the Respondent failed to check the accuracy of the

[26] The unqualified certification statement on the claims at issue is to be contrasted with certifications with qualifiers (i.e., "to the best of any knowledge and belief"). This latter type was found not to impose a duty on to check the facts in a V.A. loan application in U.S. v. Ekelman & Associates, Inc., 532 F. 2d 545, 549 (6th Cir. 1976). The court indicated it would have reached different result (imposing a duty to obtain personal knowledge) if the qualifier had not been present.

claims, as was required by the certification statements, the Respondent's negligence is more apparent. Thus, the Respondent's behavior in ignoring the certification statements, added to the Respondent's behavior in ignoring Medicaid regulations, ignoring Medicaid Bulletins, and ignoring Medicaid EOB's, added to the Respondent's behavior in interfering with Mrs. Eby and failing to check the Medicaid regulations when he disagreed with Mrs. Eby, supports a finding that the Respondent had "reason to know" that Mrs. Eby Was filing false or improper claims on his behalf.

The Respondent argues that I should find that he did not have "reason to know" about Mrs. Eby's improper activities because he delegated complete responsibility to her for submitting the Medicaid claims at issue. He argues that he had no responsibility for Mrs. Eby's improper activities. The evidence in the record requires a finding to the contrary.[27]

The Respondent, as a reasonable Medicaid provider enrolled in the Medicaid program, could have easily discovered that Mrs. Eby was filing false claims by taking a cursory look at them before they were filed; he had the requisite knowledge to know that she had no business submitting claims to Medicaid for lab tests because he admits that he ordered her to stop reimbursing labs for tests and to have the labs bill Medicaid directly.[28] The Respondent admits, in effect, that he could tell that the claims at issue were false claims on their face. *See* R Rem Br/25. What is worse, the record supports a finding that the Respondent actually interfered with Mrs. Eby when she attempted to file Medicaid claims in accordance with the Medicaid regulations. He clearly had "reason to know" because he told her what to do. Thus, the Respondent had a duty to ensure that those claims

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[27] If the Respondent had hired a competent billing clerk, properly delegated the Medicaid billing function to her, properly supervised her, and not interfered with her once she was properly trained, the Respondent would not be liable under the CMPL and Regulations.

[28] The factual situations in the three cases principally relied upon in the Deputy Under Secretary's application of the "reason to know" standard involved physically observable conditions. *See* Madison v. Desert Livestock Company, 574 F.2d 1027 (10th Cir. 1978); Samuels v. Empresa Linkas, 573 F.2d 884 (5th Cir. 1978); Christians v. Homesake Enterprises, Ltd., 25 Wis. 2d 25, 303 N.W.2d 608 (1981). Here, the condition was also physically observable, if Dr. Silver had only taken five minutes to glance at one of the 418 claims at issue.

being presented were for services provided as claimed because he caused the false claims at issue to be presented.

The Respondent had sufficient information from which a reasonable person in his circumstances would have known that further investigation of the claims at issue was warranted for several reasons. First, the Respondent had participated in Medicaid since 1973. He was the top physician biller to Medicaid in the State of Nevada during 1981, and was among the top five billers in the State during each of the five years prior to the hearing in this case. TR 1/182. In addition, during 1982, approximately 47 percent of the line item entries on the Respondent's billings were for laboratory work. IG Ex M. The claims at issue represented a very substantial portion of the Respondent's substantial billings to the program.

Second, the Respondent was sent the Medicaid Billing manuals in 1981 and in 1982 and was periodically sent all of the relevant Medicaid Bulletins at his billing address. The 1982 Billing manual was accompanied by a cover letter, addressed to "Dear Doctor." IG Ex 426/1, FFCL 11, 13. When asked what she would do when educational bulletins came in, Mrs. Eby testified she would put them on the Respondent's desk, "for him to see what information came down from Medicare, Medicaid." TR I/100. Third, a review of these Medicaid documents would reveal that the submission of a claim for an actual laboratory test when not performed and not reimbursed by a physician is a false claim.

The Respondent demonstrated a clear understanding of SAMI reimbursement rates (TR IV/533, 544-545) and billing restrictions (TR IV/533-534). The Respondent's knowledge of SAMI reimbursement requirements was demonstrated by his decision to change his financial relationship with the laboratories performing tests for him for the period at issue. When SAMI changed its rules to limit reimbursement to actual charges, which would preclude any profit to the Respondent on these billings, the Respondent decided to change his procedure to let the labs handle billings directly with Medicaid. TR I/61, 111/544. Since the Respondent was no longer performing the tests himself and was not reimbursing an outside laboratory for the work, the Respondent was not permitted by the Medicaid rules and regulation to bill SAMI at all for these tests or for any handling fees; there was no need to file a claim at all. TR 1/143, 148-149; IG Ex. 426/9. However, the claims received by SAMI were filled out in an identical manner to claims submitted during the period when the Respondent was reimbursing laboratories directly. TR I/78. This change in procedures was

immediately preceded by notifications from SAMI that the program would not pay for handling fees for lab tests (when there was an office visit or an exam billed) for urine cultures, pap smears, urinalysis, and vaginal cultures. IG Ex. B-1; TR I/40-41, 90-91.

Finally, as stated above, the record contains evidence that it was the Respondent who instructed Mrs. Eby on how and what to bill, and that he and Mrs. Eby had argued about billing issues. I find that laboratory tests and handling fee billings were among the billing issues they argued about. As I discussed earlier, the record indicates that Ms. Eby had previously been informed that handling fees were not reimbursable, had received EOB's denying payment for handling fees and had considerable experience in medical billing.

I find that she knew about the improper billing and would not have continued the practice without instructions from the Respondent which would interfere with her usual billing procedures. In spite of this evidence, the Respondent claims that he "had no prior warnings or notifications of any alleged misbillings or of any other kinds of errors." R Rem Br/8. This statement is contrary to the evidence in this record. The Respondent was frequently sent EOB's in the period just before the time period at issue which detailed denials of handling fees. Medicaid informed the Respondent in these EOB's that Medicaid would not pay handling fees for lab tests (when there was an office visit or an exam) for urine culture, pap smears, urinalysis and vaginal cultures. When Mrs. Eby attempted to claim handling fees in such situations just prior to the time period at issue, the Medicaid carrier would deny the fee, itemize that fact on the EOB form and send the form addressed to the Respondent at his billing address.

This certainly put the Respondent on notice and gave him "reason to know" that either Mrs. Eby was incompetent or that his own instructions to her were dead wrong; he never bothered to check.[29] The I.G.'s proof that the Respondent had a conversation

[29] Moreover, other prior actions of Medicaid put the Respondent on notice of Medicaid rule violations. From 1973-1978, Respondent operated an unlicensed laboratory at his office in Boulder City, Nevada and he was informed of this fact in 1977. He made no effort to investigate the problem or correct it. In 1978, Respondent was informed that he had been billing incorrectly for comprehensive exams and this abuse of the Medicaid program would have to cease. Yet, the Respondent neglected to notify his billing clerk. With respect to these latter two incidents, the

with Mrs. Eby in which she attempted to inform him that Medicaid did not pay for handling fees, that he told her that he did not believe that and that, in effect, he told her to continue to bill for such services is corroborated by the Respondent's testimony that he believed Mrs. Eby did continue to bill for handling fees. TR III/544. He even offered to take a lie detector test that he believed the claims were for handling fees.

The Respondent's voluntary decision to ignore the legal requirements of the claiming process does not excuse him from liability. In discussing the reasonable person concept, Professor Keeton, in Keeton and Prosser on Torts (Fifth Edition), states (at page 182) that "it seems clear that the actor must give to his surroundings the attention which a standard reasonable man would consider necessary under the circumstances and that he must use such senses as he has to discover what is readily apparent." Professor Keeton states (at page 185): the actor may "be engaged in an activity, or stand in a relation to others, which imposes upon him an obligation to investigate and find out, so that the person becomes liable not so much for being ignorant as for remaining ignorant; and this obligation may require a person to know at least enough to conduct an intelligent inquiry as to what he does not know." Voluntary ignorance is equivalent to negligence. Gobrecht v. Beckwith, -135A-.20,22 (1926).[30]

Opinion stated that they do not show that Respondent had "reason to know" that the claims in issue warranted further investigation. Opinion, p. 37 to 38. However, these incidents are probative of the Respondent's motives and attitudes towards the Medicaid program. While motives and attitudes are not in issue in CMPL proceedings, they can reinforce and explain findings with respect to issues in dispute. In the case at bar, these incidents help explain why the Respondent chose to ignore Mrs. Eby in their arguments over billing issues and why he chose not to investigate the claims at issue.

[30] Moreover, even if the Respondent had none of the notices cited above that made his duty to investigate spring into existence, the Respondent was negligent "for failing to train and supervise Mrs. Eby." While the Deputy Under Secretary referred to the Respondent as "careless," he was so careless that it gave rise to "reason to know." *See* Opinion, p. 39. It is helpful to look at a few cases in an expanding area of tort law, negligent hiring,

Thus, as a reasonable Medicaid provider who countermanded Mrs. Eby's intent to file proper Medicaid claims, the Respondent would have determined whether the claims he submitted to SAMI were for reimbursable services and whether the services claimed were actually provided. He also would have checked the claims presented against his own ledger cards to ensure that the services for which he billed SAMI were actually-provided en those dates. Ignorance is no defense; a respondent becomes liable for remaining ignorant, especially, as here, when he, as a reasonable medical provider, has an obligation to conduct an intelligent inquiry concerning his submission of Medicaid claims, especially when his billing clerk told him what the Medicaid regulations provided for and he argued with her.[31]

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training, and supervision. In Ponticus v. K.M.S. Investments, 331 NW 2d 907 (1983), a case where a resident manager raped a tenant, Minnesota imposed a duty on landlords to investigate their employees; the Court held that an investigation would have revealed that the manager was on parole for armed robbery and that it was foreseeable that he might commit another violent crime. *See also* City of Oklahoma v. Tuttle, 471 U.S. 808 (1985); Burch v. A&G Associates, 333 N.W. 2d 140 (1983); Williams v. Feather Sound, 386 So 2d 1238 (1980). In Cuttler v. Farmington, 498 A. 2d 316 (N.H. 1985), the Court found a town negligent for failing to adequately train its police. I find that the Respondent did have a reckless disregard for the Medicaid program's ground rules and regulations in delegating the important function of billing to Mrs. Eby without exercising proper supervision over her. I find and conclude that the reckless disregard of the Respondent was tantamount to "reason to know." The Respondent, if he was a reasonable medical provider submitting claims and exercising ordinary care, at the very least, would have made himself familiar with the rules and regulations for presenting Medicaid claims, or hired, trained or supervised someone competent to do so. *See also* Panama R. Co. v. Bossee, 249 U.S. 41,(1919); 53 AM Jur 2d, Master and Servant section 404; Forrester v. Southern Pac. Co., 134 P. 753, 764, 36 Nev. 241 (1913); Curtis, Liability of Employers for Punitive Damages Resulting From Acts of Employees, 54 Chi-Kent L. Rev. 829-850 (1978); *see also* Kellerman v. Askew, 541 F.2d 1313 (10th Cir. 1983)(inadequate amount of supervision).

[31] See discussion in "Keeton and Prosser" on knowledge and care required of professionals (at pp. 185 to 193).

Instead, the Respondent did not want to be bothered by paperwork or clerical duties or to be involved with matters that he considered to be beneath him. Because he is not fond of governmental intrusion or regulation (with regard to the practice of medicine) and does not like the burdens placed upon him by Medicare and Medicaid, he purposely remained ignorant of these rules and regulations. *See* R Rep Br/5. He saw these regulations and rules as bureaucratic and bothersome. I find that his actions and his words illustrate that he views these persons or agencies imposing these burdens and regulation as antithetical to the efficient practice of medicine as he sees it. *See, e.g.,* Rep. Br/ 4, 5. He thought he knew better than the Medicaid people whom he thought knew nothing about the practice of medicine. He thought he should get paid extra for handling fees for lab tests such as pap smears, vaginal cultures, urine cultures and urinalysis, regardless of any Medicaid rules and regulations and regardless of what Mrs. Eby told him.[32]

VII. The Appropriate Amount of the Penalty, 'Assessment, and Suspension

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

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[32] I find that the Respondent's argument that "misbillings" were apparent to Medicaid on the face of the claims, is contrary to the evidence in the record. I.G. Ex 1, B, C. Mrs. Kidd, a BSN claims processor, testified that the false claims in issue indicated on their face that the Respondent was seeking reimbursement for his payments to the outside labs (despite the fact that the dollar amounts were not indicated in box No. 22 on the claim forms). I.G. Rep Br/2; TR 11/ 253, 257-258. But, the Respondent's argument only points out his own negligence. A cursory look at the claims at issue by him should have immediately alarmed him, as the person with knowledge of his own operating procedures, that the claims were false.

As stated earlier, the penalty can be up to $2,000 for each improper service, the assessment can be up to twice the amount claimed, and there is no limit on a suspension. While the CMPL and Regulations require consideration of aggravating and mitigating factors to determine the appropriate amount of the sanctions to be imposed in a given case, there is no formula for computing them and there is little guidance to be found in the CMPL and its legislative history (except with regard to assessments).' The preamble to the Regulations states that "fixed numbers" have been "eliminated" as "triggering devices," emphasizing that discretion is preferable to a mechanical formula. 48 Fed. Reg. 38827 (Aug. 26, 1983). Section 1003.106(b) of the Regulations contains some general guidelines for the interpretation and application of the aggravating and mitigating factors.

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

Congress intended the penalty to be a deterrent rather than to be retribution or punishment. *See* Mayers v. U.S. Department of Health and Human Services, 806 F. 2d (11th Cir. 1986); see also, Chapman v. United States of America, Department of Health and Human Services, F.2d (10th Cir., June 15, 1987). A deterrent is meant both to encourage others to comply with the law and to discourage a respondent from committing the wrong again. Retribution or punishment goes well beyond this point and might raise constitutional questions. To arrive at an appropriate penalty that would be a deterrent, rather than retribution, the ALJ must consider the factors outlined in the regulations, weigh the gravity of the wrong done by a respondent, and consider what it would take to prevent the wrong from being committed again by a respondent and others. Taking this into consideration, the penalty I deem appropriate in this case is meant to be proportionate to the offense committed by the

respondent, as indicated by the facts in the record, and is meant to be a deterrent rather than punishment. The purpose of assessments in CMPL cases is to enable the United States to recover the damages resulting from false or improper claims; this includes amounts paid to the Respondent by Medicaid and the costs of investigating and prosecuting unlawful conduct. *See* 48 Fed. Reg. 38831 (Aug. 26, 1983).

Section 1003.107 of the Regulations requires the same criteria used in determining the penalty and assessments to be used to determine the length of any suspension imposed. The purpose of the suspension is deterrence and protection of the Medicare and Medicaid programs. 48 Fed. Reg. 38832 (Aug. 26, 1983).

A. The Degree of Culpability of the Respondent

One of the most complex of the factors to be considered by the ALJ in determining the amount of the penalty is the "degree of culpability." The guidelines in the Regulations indicate that this factor relates to "the degree of the Respondent's knowledge and intent." As stated earlier, it is a prerequisite that a respondent "knew or had reason to know" that the claims were false or improper in order for liability to attach. Knowledge, however, is an aggravating factor, and "unintentional or unrecognized error" is a mitigating factor if the Respondent "took corrective steps promptly after the error was discovered." Regulations Section 1003.106(b) (2). The determination of the degree of culpability in this case involves an inquiry into the degree of the Respondent's knowledge. *See* 48 Fed Reg. 38831 (Aug. 26, 1983).

Here, the I.G. did not prove by a preponderance of the evidence that the Respondent had actual knowledge that the claims were improper. The I.G. did prove that the Respondent had "reason to know" the claims were improper, by showing that the Respondent insisted that Mrs. Eby continue to seek Medicaid reimbursement for services that Medicaid did not reimburse and by showing that the Respondent acted contrary to the certification statements on the claims.

The Respondent's insistence, in light of Mrs. Eby's knowledge and experience with the submission of Medicaid claims, was enough to alert the Respondent to the possibility that Mrs. Eby might be correct; to order her to submit the claims the way he insisted was reckless and he had "reason to know" that Mrs. Eby might take action inconsistent with Medicaid rules and regulations, such as falsifying the claims in order to deceive

Medicaid into paying for non-reimbursable services. The Respondent did not exercise due care in his supervision of Mrs. Eby and his negligence was compounded by the pressure he exerted on Mrs. Eby to seek reimbursement for handling fees, pressure which caused her to falsify the claims at issue here.

The Respondent is liable under the CMPL because his actions created a duty to investigate the claims being filed on his behalf. Because the I.G. did not prove that the Respondent actually knew the false content of the claims, the Respondent's culpability is lessened. Culpability is still present, however, and although it moves toward the minimum "outer limits," it does not exceed or even reach those limits. *See* Opinion, p. 41. In light of the lack of evidence of actual knowledge and my assessment of the weight of the Respondent's culpability under the "reason to know" standard, I conclude that the Respondent's degree of culpability should mitigate the penalty, assessment, and suspension imposed.

B. The Nature and Circumstances of the Claims and Services at Issue

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

Since the guideline examples of aggravating circumstances are couched in the disjunctive, only one need be proven by the I.G. to establish the nature and circumstances as an aggravating circumstance. Here, the I.G. has established more than one. On the other hand, the guideline examples of mitigating circumstances are couched in the conjunctive; all must be proven by the Respondent in order to have the nature and circumstances

of the claims at issue to be considered mitigating. The Respondent did not prove all of them.

The I.G. proved by a preponderance of the evidence that the Respondent billed for substantial sums (considering the items were for lab tests for a period of over two years) and the period was lengthy. The services billed for were not for several types and a pattern was not proven by a preponderance of the evidence. Although the improper claims were for several types of lab tests, they were not for several types of dissimilar services.

C. History of Prior Offenses

The next factor discussed in the Regulations is "prior offenses" of a respondent. The guidelines at section 1003.106(b) state that an aggravating circumstance exists if, for to the presentation of the improper claims at issue, a respondent was held liable for criminal, civil or administrative sanctions in connection with one of the programs covered by the CMPL or any other medical services program. This guideline would clearly prevent consideration of mere allegations of past wrongdoing; a respondent must have been "held liable" and subjected to actual sanctions before committing the acts for which he is found liable. The preamble makes clear that prior offenses are not an aggravating circumstance, unless there has been a final agency determination or a final adjudication in a court. 48 Fed. Reg. 38832 (Aug. 26, 1983). There are no prior offenses which would be considered an aggravating factor in this case. Absence of a prior offense is not a mitigating factor under the Regulations.

D. Other Matters to be Considered as Justice Requires

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

The I.G. proved that the Respondent violated Nevada law by operating an unlicensed laboratory (the Respondent argued that this was only a minor violation, because the Respondent employed a licensed or certified lab technician) and that the Respondent submitted claims from 1973 to 1978 for lab tests performed by this unlicensed lab in violation of SAMI rules and regulations (*see* I.G. Ex 426). This is not an aggravating circumstance, as

alleged by the I.G., because the State never took action with regard to these violations, even though this is another illustration of the Respondent's reckless disregard of the Medicaid rules and regulations. It is a mitigating circumstance that the I.G. did not meet his burden of proof with regard to two claims at issue and with regard to the allegations that there were six crossover claims received and processed by the Medicare carrier (Aetna).

I have also considered the fact that the Respondent reached a settlement agreement with the State concerning his misbillings and agreed to a voluntary withdrawal from Medicaid for 3 years (there was no criminal conviction). *See* R Rep Br/14. This does not constitute a mitigating circumstance. *See* Chapman v. United States, et al., supra, Slip Op. at pp. 13-14. However, as the I.G. agreed, it is appropriate for the assessment to be reduced by the amount of restitution recouped by the State in this case (i.e., $8,762.41). *See* I.G. Br/62.

Although there was no direct adverse impact on Medicaid recipients proven, the I.G. did prove that there was sloppiness in record keeping and office procedures which could have indirectly been detrimental to Medicaid recipients. The Respondent has hired experts to correct this situation. Particularly because no concrete proof of harm was made, this is not an aggravating circumstance. It is also not a mitigating circumstance.

E. Financial condition

The Regulations state that the financial condition of a respondent would constitute a mitigating circumstance if the penalty or assessment, without reduction, would jeopardize the ability of a respondent to continue as a health care provider. Thus, it is clear that the ALJ may consider the Respondent's financial condition (a traditional element evaluated in compromising or settling claims). Furthermore, the guidelines at section 1003.106(b) (4) note that the ALJ must consider the resources available to a respondent. This indicates that financial disclosure by a respondent is a key requirement in evaluating a respondent's financial condition. The Respondent did not offer evidence of his financial condition. Thus, financial condition is not a mitigating factor.

VIII. The Amount of the Penalty, Assessment, and Suspension, As Modified Here, Is Supported by the Record

After weighing all of the aggravating and mitigating circumstances present in this case, I reduce the penalty to $73,500; the assessment to $9,000; and the suspension to three years. The I.G. proposed a penalty of $232,000; an assessment of $18,000; and a ten-year suspension. On remand, the Respondent argued that, if liability is found, the penalty and assessment should be no greater than double the amount of money received by Dr. Silver from Medicaid (less restitution paid to the State) and no suspension other than the three years of voluntary suspension. (The Respondent contended in his earlier brief that the penalty and assessment should not total more than $184,087, twenty times the amount of money paid to the Respondent by Medicaid, arguing that the so-called twenty-times rule is binding on the I.G.) *See* R Rem Br/24 to 28. *See also* R Rep Br/15, 16.

The amounts of the penalty, assessment and suspension that could have been imposed under the CMPL and Regulations are much greater than the amounts actually proposed by the I.G. As stated earlier, the penalty is intended to serve as a deterrent to future unlawful conduct in the Medicare and Medicaid programs; the assessment is meant to make the Government whole; the suspension is meant to protect program integrity. In its report on the CMPL, the House Ways and Means Committee found that"civil money penalty proceedings are necessary for the effective prevention of abuses in the Medicare and Medicaid program. . . ." H.R. Rep. No. 97-158, 97th Cong., 1st Sess. Vol. III, 329 (1981). I have reevaluated the penalty in light of the implications of the Respondent's culpability under the "reason to know" standard of liability and I find that $232,000 is too high. *See* De La Calenas v. Perales, 495 NYS 2d 383 (A.D. Dept. 1, 1985). I find that a penalty of $73,500 is more appropriate.

This amount is three percent (3%) of the maximum possible and approximately one-third (32%) of the amount proposed by the I.G. I also find an assessment of $9,000 and a suspension of three years to be more appropriate. In imposing the three year suspension, I have taken as a guideline the standard period imposed in debarments to protect the integrity of government programs. *See* 47 Fed. Reg. 28854 (June 24, 1982). After weighing all of the aggravating and mitigating circumstances, I conclude that a penalty of $73,500 is a sufficient deterrent under the circumstances of this case, that $9,000 is sufficient to

compensate the Government, and a three year suspension is sufficient for ensuring program integrity.

ORDER

Based on the evidence in the record and the CMPL and Regulations, it is hereby Ordered that the Respondent: (1) pay a penalty of $73,500; (2) pay an assessment of $9,000; and (3) be suspended from Medicare and Medicaid programs for a period of three (3) years.

/s/ Charles E. Stratton
Administrative Law Judge