DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Grant Appeals Board

Office of Hearings for Civil Money Penalties

In the Case of:	
The Inspector General,	DATE: Aug 26 1987
- v. -	
George A. Kern, M.D.,	Docket No. C-25
Respondent.	DECISION CR 12

DECISION AND ORDER

In this case, the Inspector General (I.G.) of the United States Department of Health and Human Services (DHHS) issued a Notice of Determination (Notice) informing George A. Kern, M.D. (the Respondent), that the I.G. sought a penalty of $215,000, an assessment of $15,510, 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 false or improper claims for Medicare payment. 1/ 2/ The I.G. alleged that the medical services listed by the Respondent as having been performed at the Iowa Methodist Medical Center (IMMC), during the period from September 15, 1981 through December 16, 1983, were not provided to the Medicare beneficiaries as claimed.

The Respondent filed a timely answer denying the I.G.'s allegations, challenging the proposed sanctions, and

---

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) (1983)(1986 Supp). 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.

requesting a hearing before an Administrative Law Judge (ALJ).

JURISDICTIONAL AND PROCEDURAL BACKGROUND

The Respondent, Dr. Kern, practiced general medicine in Des Moines, Iowa, from 1954 until he surrendered his license on December 24, 1985. TR IV/1019 to 1022. Dr. Kern participated as a medical provider in the Medicare program from its inception in 1966 to 1985. Stip/8, 9. During the period at issue, the Respondent had medical staff privileges as a general practitioner (GP) at IMMC and admitted patients there. Stip/11.

The I.G.'s Notice in this case was issued on March 27, 1986. In the Notice, the I.G. alleged that 330 line items for medical services claimed by the Respondent in 69 Medicare claims were false or improper because the respondent "knew" or "had reason to know" that these services were "not provided as claimed." Specifically, the I.G. alleged that the Respondent presented or caused to be presented claims and received Medicare payments for (1) hospital admissions (admits) to the IMMC which he did not provide "as claimed," and (2) hospital visits (visits) to Medicare beneficiaries at the IMMC which he did not provide "as claimed." The Respondent's answer and request for a hearing, received June 9, 1986, refuted the I.G.'s allegations and asserted that the Respondent did provide the Medicare services as claimed.

At the prehearing conference on August 6, 1986 in Washington, D.C., the I.G. withdrew 10 of the 330 services at issue, reducing the services at issue to 320. The services which were withdrawn (listed in the schedule attached to the I.G.'s Notice) are Nos. 50, 51, 52, 102, 113, 114, 115, 116, 117, and 321.

A formal evidentiary trial-type hearing was held in Des Moines, Iowa, from October 27 through October 31, 1986 and from November 5 through November 6, 1986. Twelve witnesses testified on behalf of the I.G., and eight witnesses testified on behalf of the Respondent. Subsequent to the hearing, the I.G. withdrew six more services at issue (Nos. 137, 138, 184, 186, 187, 188) and at the hearing the I.G. withdrew one more service at issue (No. 214), reducing the total number of services at issue to 313. See, TR III/737. The I.G. modified the proposed penalty to $203,925.00 and the proposed assessment to $14,870.00.

The I.G. and the Respondent presented post-hearing briefs, findings of fact and conclusions of law, and reply briefs. Also, in light of the Deputy Under Secretary's April 27, 1987 opinion in the case of The Inspector General v. Frank P. Silver, M.D., Docket No. C-19, OHCMP/DGAB (Opinion), I requested that the parties file an additional brief. The I.G. filed a brief, as requested, but the Respondent's attorney, after being granted a requested extension of time, failed to do so.

In both the Notice and in the heading of the attached schedule to the Notice (schedule), the I.G. identified the period during which the claims were submitted as ending on December 16, 1983. Nevertheless, two of the claims, listing three services at issue in the schedule, are dated January 6, 1984 (schedule Nos. 70, 71, 72; See I.G. Ex 10A, 11A). Another claim in the schedule showed the amount billed by Respondent as $20. In fact, the amount actually billed was $45. See, I.G. 4A (schedule No. 5). Accordingly, these claims, listing four (4) services, are stricken for lack of notice. Thus, 53 claims and 309 services remain at issue.

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. See, Regulations section 1003.102. 3/ Once a respondent is 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.

3/ A person eligible for Medicaid benefits is defined at 42 C.F.R. section 400.203 as a "recipient" and a person eligible for Medicare benefits is defined at section 400.202 as a "beneficiary."

The intended purpose of imposing a civil money penalty is to deter persons from presenting false or improper Medicare or Medicaid claims (or from making requests for payments to Medicaid recipients 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; 344 (1981); S. Rep. No. 139, 97th Cong., 1st Sess. 461-62 (1981), 1981 U.S. Code Cong. & Ad. News 727-28; 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 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

To establish liability by a preponderance of the evidence adduced during the proceedings in a case, 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). 4/ 5/

To establish liability in this type of case, the CMPL and Regulations require the I.G. to prove that: (1) the Respondent (a "person") (2) "presented or caused to be presented" (3) the "claims" at issue (4) to the Medicare or Medicaid programs ("agency") (5) for medical "items or services" when, in fact, (6) reimbursable medical services were "not provided as claimed," and (7) the Respondent "knew or had reason to know" that the services were not provided as claimed. CMPL section 1320 a-7a(1) (A); Regulations section 1003.102 (a) (1). See, Scott, at pages 26 to 28.

III. Application of the "Knew or Had Reason to Know" Standard of Liability Under the CMPL and Regulations

The elements of liability set forth in the CMPL and Regulations are straightforward and need little interpretation, with the exception of the element of scienter -- the most difficult element to apply. 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." See, The Inspector General v. Jimmy Paul Scott, OHCMP/DGAB, at p. 26. 6/ Proof of actual knowledge or proof that a respondent had "reason to know" is all that the CMPL and

---

4/ 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.

5/ 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.

6/ The CMPL and Regulations contain slightly different language with identical meaning. Under section 1320 a-7a(1)(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."

Regulations require for liability to attach. 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). 7/ As I also stated in Scott, in analyzing the term "reason to know," the Restatement of Torts (2d) (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 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, the "reason to know" standard employs the "reasonable person" (objective knowledge) concept. See also, Restatement of Agency (2d), section 9, comments (d) and (e) (1957). In discussing objective knowledge, Professor Keeton, in Keeton and Prosser on Torts, (Fifth Ed. 1984), states at page 182 that one of the most difficult questions (in connection with negligence) "is that of what the actor may be required to know." 8/

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 of Torts (2d) 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

---

7/ It should be noted that proof of actual knowledge is considered to be an aggravating factor. Regulations section 1003.106(b)(2).

8/ For a discussion of subjective knowledge and objective knowledge, see Seavy, "Negligence-Subjective or Objective," 41 Harv. L. Rev. 1, 17; see, also, Restatement of Torts (2d), sections 289, 290.

> 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 attaches where: (1) a 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) a respondent has an obligation to investigate and find out whether certain services are billable under the Medicare or Medicaid programs (such as a duty which would require a respondent to verify the truth, accuracy, and completeness of claims presented). See, Scott, pp. 25 to 30. Thus, where the Respondent in this case acted negligently in light of information that came to his attention, or purposely ignored Medicare rules and regulations of which he had notice, or ignored pre-existing requirements or duties (such as a Medicare requirement to examine the claims at issue before they were presented to Medicare), he is liable under the CMPL for the false or improper claims filed.

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 have concluded that the phrase "knows or has reason to know" encompasses a spectrum where liability attaches on one end when a respondent files false claims with actual knowledge and on the other end where a respondent files false or improper claims in a negligent manner. See, Scott, supra.

To determine whether a respondent acted negligently for purposes of liability under the CMPL and Regulations, the reasonable person standard is used. In applying the reasonable person standard, a respondent's actions should be considered in relation to a person of "ordinary" intelligence, taking into account "the superior intelligence" of a particular respondent. See, Restatement of Torts (2d), section 12. In other words, a respondent should be judged in terms of his degree of education, skill, and experience. A respondent should also be judged in terms of his relation to others, such as his Medicare patients and the Medicare program itself; he should be judged as a reasonable medical provider.

Under the "reason to know" standard of liability, there are at least two situations where a negligent medical provider would be found liable for submitting false or improper claims. The first is where sufficient information came to a medical provider's attention to spring into existence a duty to investigate the accuracy of the claims. See, Silver Opinion, p. 2. The second situation is where "pre-existing duties" are ignored by a medical provider. Pre-existing duties vitiate the need for "independent proof" in causing the duty to investigate "to spring into existence." See, Opinion, p. 39, n. 15. 9/ On this point, Keeton and Prosser on Torts, supra, at p. 185, states: "he may, furthermore, be engaged in an activity, or stand in 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." (Emphasis added.) In other words, voluntary ignorance is equivalent to negligence. Gobrecht v. Beckweth, 82 N.H. 415, 420, 135 A 20, 22 (1926). A medical provider cannot be allowed to reap the benefits of the Medicare program while purposely remaining ignorant of its rules and requirements.

Once it has been determined that a medical provider did not act as a reasonable medical provider, a judgment must be made as to what the results would have been if he had investigated, had not ignored pre-existing duties, or had conducted an intelligent inquiry as to what he did not know.

THE MEDICARE PROGRAM IN IOWA

I. Background

Medicare is a federally administered program of Health Insurance for individuals who are age 65 or older or disabled. See, Title XVIII of the Act (42 U.S.C., section 1395, et seq.). Part B, which is involved in this case, provides a voluntary subscription program of supplementary medical insurance generally covering 80% of the reasonable

---

9/ One such pre-existing duty is the duty of quality medical care owed by a physician to a patient.

charges for physician services, x-rays, laboratory tests, and medical supplies. 42 U.S.C. sections 1395k, 1395r, and 1395x(s). 10/ Benefits under Part B are financed from the Federal Supplementary Medical Insurance Trust Fund (funded by appropriations from the Treasury and by premiums paid by individuals who choose to enroll in the Part B program). 42 U.S.C. sections 1395j, 1395r, 1395s, 1395t(a), 1395t(g), and 1395w. See, generally, Schweiker v. McClure, 456 U.S. 188, 189-190 (1982).

II. The Medicare Carrier in Iowa

To assist in the administration of the Part B program, Congress authorized the Secretary of DHHS to contract with entities known as carriers. 42 U.S.C. section 1395u(f); 42 C.F.R. section 400.202. Carriers perform a variety of functions for the Secretary, such as establishing rules and regulations for the submission of Medicare claims, determining the rates and amounts of payment for covered services, disseminating information regarding Medicare rules and regulations, and processing and paying claims. 42 U.S.C. section 1395u. Blue Shield of Iowa (BSI) was the Medicare carrier for DHHS in Iowa at all times relevant to this action. Stip/7. 11/ In that capacity, BSI disseminated information about how to properly file claims and processed and paid claims submitted by Iowa

---

10/ There are also Parts A and C. Neither are involved here. Part A provides insurance for certain types of hospital and post-hospital services. Part C contains miscellaneous provisions applicable to the programs under both Parts A and B.

11/ Reference to the briefs, the transcript, the stipulations, hearing exhibits, and to the Findings of Fact and Conclusion of Law contained herein are as follows:

I.G.'s Brief	=	I.G. Br/[page]
I.G.'s Reply Brief	=	I.G. Rep Br/[page]
I.G.'s Supplemental Brief	=	I.G. Supp Br/[page]
Respondent's Brief	=	R Br/[page]
Respondent's Reply Brief	=	R Rep Br/[page]
Transcript	=	TR [volume number]/[page]
Stipulations	=	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]

medical providers for items or services that the providers stated were rendered to Medicare beneficiaries.

III. Dissemination of Medicare Notices and Information to Providers

The carrier, BSI, provided physicians and others who filed Medicare claims with a variety of informational sources concerning Medicare requirements for the submission of proper claims. These BSI requirements implemented rules, policies, regulations, and statutory provisions. The Medical Assistant's Manual (Medicare Manual) was made available to all physicians who had "provider numbers;" during the period in question, the Medicare Manuals were BSI's method of informing providers about the legal and correct way to bill. TR I/143. Also, changes and new developments in the use of procedure codes for billing purposes and any other Medicare policy modifications were distributed by BSI to all providers by way of updates to the Medicare Manual and by way of newsletters. TR I/172. Everyone who had a provider number received a copy. See, I.G. Ex 64A, B, and C; TR I/137 to 138, 155. BSI's newsletter was called the "Medicare Bulletin" in 1980 and "Medicare B On Record" in 1981. I.G. Ex 64A; TR I/138. To supplement the written information, in-service training was available for billing clerks and providers. TR I/159-160. Also, telephone lines were available for billing questions and problems. TR I/176.

IV. The Medicare Claim Forms and Procedure Codes

A. The Medicare Claim Forms

The claim forms that BSI has used since 1980 are known as the "HCFA 1490" and the "HCFA 1500". See, I.G. Ex 86A, 86B. All but one of the claims at issue in this case were submitted on one of these two types of forms. By signing the HCFA 1490 or 1500 form, the medical provider certifies that the services for which reimbursement was sought were medically necessary for the patient's health and were personally rendered either by the medical provider or under the provider's personal direction. I.G. Ex 86A and 86B; TR I/132, 169. The HCFA 1500 form also contains a notice regarding the truth, accuracy, and completeness of the claim. The Respondent provided a HCFA 1500 certification on fifty of the claims at issue involving

295 of the 309 services at issue. See, FFCL. 12/ Both claim forms state that anyone who misrepresents or falsifies essential information to receive payment from Federal funds claimed may be subject to sanctions under applicable Federal laws.

B. The Relevant Procedure Codes

In order to identify the services claimed, Medicare providers were required to define the services through the use of procedure codes designated by BSI. Until mid-1983, BSI used the Iowa Relative Value Index Codes (IRVIC). BSI then began using the current procedural terminology (CPT) codes, found in the American Medical Association's CPT-4 book, in conjunction with the Health Care Financing Administration (HCFA) Codes. (HCFA is the administration in DHHS which administers the Medicare program. TR I/135-136.)

During the period at issue, physicians received instructions from BSI regarding procedure coding. The instructions included specific descriptions of what codes to use for what services and the requirements to be followed to document the services performed. TR I/136; I.G. Ex 64A, 64B/46. The procedure code for an admit was 9020 (until mid-1983, when CPT code 90220 was adopted). TR I/142. The procedure code for a routine visit was 9024 (until mid-1983 when CPT code 90250 was adopted). TR I/142.

V. The Pertinent Medicare Rules and Requirements

A. Medical Necessity

The Medicare rules and requirements authorize reimbursement of federal funds to medical providers for "medical and other health services" rendered to eligible

---

12/ The HCFA 1490 and HCFA 1500 also serve as Medicaid claim forms in those instances where the Medicare beneficiary is a Medicaid recipient as well. After the Medicare claims are processed by BSI they are cross-matched with a Medicaid history tape to identify whether the Medicare beneficiary is also a Medicaid recipient. An electronic tape is then generated by the Medicare carrier and forwarded on a weekly basis to the Medicaid carrier, which processes the information and pays the providers for the coinsurance and deductible. The Respondent received payment from Medicaid in this manner. Stip/16; TR I/129-135; TR II/424-425.

Medicare beneficiaries. 42 U.S.C. section 1395k (a)(1). A physician's services are not reimbursable unless they are "reasonable and necessary for the diagnosis or treatment of illness or injury. . . ." 42 U.S.C. section 1395y (a)(1)(A). BSI set forth these and other Medicare rules and requirements in the Medicare Manual. The July, 1981 version of page 44 of the Medicare Manual noted that: "Based upon medical necessity, Medicare Part B will cover inpatient care." I.G. Ex 64B/4.

B. The Requirement that Medical Services Must Be Documented

In July, 1981, the carrier disseminated pages 28 and 29 of the Medicare Manual. Those pages emphasized the need "for all physicians to have a good medical record documentation . . . to show evidence that billed services were in fact provided." I.G. Ex 64B/1. In May, 1982, page 28 was revised. The revised version of page 28 read: "the burden of proof lies with the physician that a service was provided as billed." In May, 1982, page 21 was also revised. The revision read:

> Example: if the physician billed for 7 days of hospital care, Medicare would expect to see 7 days of physician orders or progress notes in the hospital chart. Phone orders do not constitute documentation of physician visits.

I.G. Ex 64C/1. There is credible testimony that it is a good medical practice for a physician to document hospital records at least every third day. TR I/68, 140, 198, 29; TR II/368 to 371, 390 to 391, 508 to 509. There is also testimony from an I.G. investigator that a medical provider is sometimes given the benefit of the doubt if there is not a progress note in a patient's chart every day. TR III/719.

C. Substitute Physicians

As of July, 1981, page 44 of the Medicare Manual contained the following provision:

> If one physician "covers" for another physician (i.e., on a week-end or vacation), the substitute doctor should bill Medicare for the services provided. Do not include any visits of a substitute physician on your claim for inpatient care.

This policy was restated in the Medicare Manual in May 1982. I.G. Ex 64C/7.

D. Concurrent Care

The Medicare policy on reimbursement for concurrent care (i.e., professional services provided to a hospital patient by two or more physicians at the same time) was also described in May of 1982. Moreover, the 1982 manual noted that coverage for "related concurrent care" (i.e., two or more physicians treating a patient for the same condition) is very limited, and the requirements for reimbursement are quite strict. I.G. Ex 64C/5.

E. Admits and Visits

Thirty-Eight (38) of the 309 services at issue in this case were submitted by the Respondent as a "first hospital visit", using the procedure code for a hospital admission (admit). Two hundred sixty-two (262) of the 309 services at issue were submitted by the Respondent as a "hospital visit," using the procedure code for a hospital visit (visit). 13/

The physician charge for an admit was $45 and the charge for a visit was $20. TR I/140. To legitimately bill for an admit, the physician was required to do a history and physical, initiate a diagnostic and treatment program, and prepare the patient's hospital records. TR I/138; I.G. Ex 64A. To legitimately bill for a visit, the physician was required to see the patient, perform a necessary medical service, and document the medical record with a progress note or order. TR I/140; I.G. Ex 86A, 86B.

F. Warnings to Medicare Providers

The May, 1982, the Medicare Manual specifically warned medical providers that a post-payment utilization review would be performed concerning whether services were actually performed and whether they were medically necessary. I.G. Ex 64C/2. The providers were also warned about sanctions for improper practices. I.G. Ex 64C/3.

13/ The other two procedure codes applicable to the remaining 9 (of the 309) services at issue are 0610 and 9072. Procedure code 0610 is a code used to designate a medical emergency treated in the emergency room. TR I/141. It is billed at $25. Procedure code 9072 is an intensive care unit (ICU) visit, which is billed at $45, instead of the $20 for a routine hospital visit. TR I/141.

ISSUES

The principal issues are:

A. Liability:

1. Whether the I.G. proved by a preponderance of the evidence that the Respondent "knew" or "had reason to know" that the Medicare services at issue were "not provided as claimed."

B. The Amount of the Penalty, Assessment, and the Period of Suspension (if Liability is Proven):

1. Whether the I.G. proved by a preponderance of the evidence the aggravating circumstances alleged.

2. Whether the Respondent proved by a preponderance of the evidence any circumstances that would justify reducing the amount of the penalty, the assessment, or the period of suspension proposed by the I.G.

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW 14/15/

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

1. For the purposes of this case, I have taken judicial notice of the statutes of the United States, the regulations of the Secretary of DHHS, all other pertinent regulations of the United States, the statutes of the State of Iowa, the regulations of the Iowa Medicare Program, and all other pertinent regulations of the State of Iowa as they existed at the time of the cause of action.

2. This case is governed by the CMPL and the Regulations. The Secretary has delegated his authority to take action under the CMPL and the Regulations to the I.G., and this authority has been redelegated to the Deputy Assistant Inspector General for Civil Fraud. Stip/3-6.

3. On March 27,1986, Eileen Boyd, the Deputy Assistant I.G. for Civil Fraud, issued a Notice of Determination (Notice) informing the Respondent that the I.G. had determined that the Respondent should be subject to a penalty of $215,000 and an assessment of $15,510. The Notice alleged that during the period October 5, 1981 through December 16, 1983, the Respondent presented or caused to be presented false or improperly filed claims for Medicare payment for 330 medical services listed as being performed at the Iowa Methodist Medical Center (IMMC), when, in fact,

---

14/ 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. Also, I have incorporated some findings and conclusions elsewhere in this Decision.

15/ 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.

the Respondent "knew" or "had reason to know" that these medical services "had not been provided as claimed," in violation of the CMPL and Regulations. A true and correct copy of this Notice and its attachment (Schedule) listing the 330 items or services is a part of the record in this case.

4. The I.G. subsequently modified the number of items or services at issue from 330 to 313 and correspondingly reduced the proposed penalty to $203,925 and the proposed assessment to $14,870. The I.G. dropped Schedule Nos. 50-52, 102, 113-117, 137, 138, 184, 186-188, 214, and 321.

5. In the Notice, the I.G. identified the covered period as ending December 16, 1983. Two of the claims set out in the attachment, listing three medical services, are dated January 6, 1984 (I.G. Ex 10A, 11A; Schedule Nos. 70-72). Also, in the attachment to the Notice, the I.G. listed the amount billed as $20 for a claim by the Respondent for a service rendered to Donald Atchison on August 23, 1982. Schedule No. 5. The Respondent actually billed $45, for an admit. I.G. Ex 4A. In all other instances in this case, the Respondent billed $20 only when he claimed for a routine hospital visit. These four services are stricken for lack of notice and are not part of this case. Accordingly, the number of claims at issue is reduced to 53 and the number of services to 309.

6. On June 20, 1986, the Respondent 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 this answer and the defenses listed therein is a part of the record in this case.

7. The Respondent was a practicing physician in Des Moines, Iowa, from 1954 until he turned in his license to the Iowa Board of Medical Examiners in December, 1985. TR IV/1019, 1022. He testified that he turned in his license to avoid a hearing by the Board on the issue of whether to suspend or revoke his license. TR VI/1566-1567.

8. The Respondent had medical staff privileges as a general practitioner (GP) at the Iowa Methodist Medical Center (IMMC) in 1981, 1982, and 1983 and admitted patients to the IMMC. Stip/11.

9. For the period at issue, Blue Shield of Iowa (BSI) was the designated Medicare fiscal agent, or carrier, for the State of Iowa. Stip/7. As such, BSI was authorized to process claims filed by physicians and other medical providers.

10. The Respondent was enrolled as a medical provider in the Medicare program on June 30, 1966 and participated from that time through January 6, 1984 using provider number 04071. Stip/8.

11. The Respondent participated in the Medicaid program, administered by the Iowa Department of Human Services (IDHS), in 1980, 1981, 1982 and 1983. Stip/9. The Respondent was paid co-insurance and deductibles by IDHS. Stip/16.

12. Since 1971, BSI has sent every Medicare provider a copy of the manual (Medicare Manual) which included information on Medicare policy and on how to submit claims. This Medicare Manual is in looseleaf form, for ease of inserting material updating the Medicare policy, rules and regulations, and billing information. TR I/156, 157, 161, 165, 170, 172, 175.

13. The Respondent denied receiving the Medicare Manual. TR IV/1024, 1571.

14. From time to time during the period at issue, BSI also sent providers Medicare policy and billing information in looseleaf form, for immediate insertion into the Medicare Manual, and in non-looseleaf bulletins (Medicare Bulletins). TR I/165, 175; see, e.g., I.G. Ex 64A, 64B, 64C.

15. BSI sent all physicians enrolled in the Medicare program the Medicare Bulletins to inform them of Medicare policy. Two or three times a year BSI also duplicated the Medicare Bulletins and sent them again to providers to update the Medicare Manual. TR I/172, 175.

16. The Respondent received the Medicare billing and policy information in both the looseleaf and non-looseleaf updates. TR IV/1026; TR VI/1571; Stip/14. The Respondent testified that he never read them and that either he or his office staff threw away the updates, including those pertaining to billing, procedure codes, and fees. TR IV/1028-1029, TR VII/1740-1741.

17. The Respondent testified that his office staff kept the procedure codes in a "teeny spiral-bound book" which they updated by "telephone contact with Blue [Shield]." TR VII/1741.

18. The Respondent also had a "Physician Manual" from BSI, but he "didn't see anything of any real value...so it just didn't get used," even though the Physician Manual had a section on submission of Medicare forms. TR VII/1734, 1735; TR IV/1024; Stip/13.

19. From 1981 to mid-1983, BSI used the Iowa Relative Value Index Codes (IRVIC). TR I/ 136. In order to identify medical services claimed, Medicare providers are required to use procedure codes to define the services they performed.

20. The American Medical Association provides physicians with a book of Current Procedural Terminology/(CPT) which contains codes for identifying various medical procedures. BSI has used the CPT codes since 1983, in addition to Health Care Financing codes (HCFC). TR I/135-136.

21. Respondent had a "CPT Manual" which he said contained "a large number of codes for Medicare procedures." TR VI/1569, 1570.

22. In claiming reimbursement for services to Medicare beneficiaries in Iowa during the period at issue, a physician was supposed to identify the service performed by use of a procedure code from the Iowa Relative Value Index Codes, the Health Care Financing Codes, or the CPT book. TR I/135, 136.

23. Thirty-eight (38) of the services listed in the claims at issue were coded 9020 or 90220, which is a hospital admission (admit). TR I/142. The Respondent designated an admit as a "first hospital visit" on the claims at issue.

24. BSI defined a reimbursable admit to include a brief history and physical examination, initiation of diagnostic and treatment program, and preparation of hospital records. TR I/138; I.G. Ex 64 A/2.

25. The Respondent testified that these elements constituted an admit:

    a. Pre-hospital assessment to establish medical necessity.

    b. Physically getting a patient to the IMMC, along with records, transfer information, and medications.

    c. Making arrangements at IMMC to determine that a bed is available and to ascertain where the hospital will locate the patient.

    d. Performing a physical examination of the patient and executing a written record of the patient's medical history and the results of the physical examination.

    e. Setting up a written plan of, and schedule for, treatment of the patient.

    f. Sometimes arranging for a consultant to see the patient, giving the consultant information on the patient's illness, past medical history, and physical condition.

    g. Passing information to the patient, the patient's family, and the nursing home, and conferring with the patient's family regarding the hospital stay.

    h. Making arrangements to discharge a patient and to transfer a nursing home patient back at the end of a hospital stay.

    TR IV/1065-1066; TR V/1228-1229.

26. The Respondent estimated that the history and physical (H&P) part of an admit took only 10 to 20 percent of the total time that he spent on an admit. TR V/1230; see, also, TR IV/1065.

27. The Respondent said that he performed an H&P "to know what's going on," but whether or not he wrote it "on a piece of paper" didn't make "any difference." TR IV/1599. He said that it was his practice to examine a patient on the day of admission "or right in that area," but he might not do the actual writing or dictating of the H&P until later, sometimes a month later, because he "forgot to write it down or more likely the dictating machine was busy." He said that

the IMMC had only one dictating machine per floor (40 patients). TR I/1229-1230. The Respondent acknowledged that not only was it "standard procedure" and a "hospital requirement," but also "good medicine" to do an H&P. TR VI/1611.

28. The Respondent testified: "I actually write down the assessment of the patient and the plan of treatment myself, or tell somebody else this is what I'm going to do, and the somebody-else writes it down." TR VI/1599.

29. The IMMC requires that an H&P state the chief complaint, or reason why the patient is in the hospital; the review of the patient's body systems; and the record of the physical examination of the patient. TR I/187, 210. This information is usually recorded on a form (MR 12), but the IMMC also accepts it in the form of a progress note (PN) or an emergency room assessment or report, as long as all of the elements stated above are set out in the PN or the assessment/report. Id.

30. IMMC requires that a history and physical be on record within 48 hours of the time of the admission of a patient. If the patient is to undergo surgery, the history and physical must be on record prior to the surgery. TR I/185- 186; I.G. Ex 65/46.

31. BSI requires that physicians document their Medicare billing for an admit with a plan of treatment or admit order, and an H&P. TR I/68, 69, 80. An H&P may be in the form of an admit order, but must include a written report and explanation of the patient's condition. TR I/62, 70. The H&P must be done by the physician submitting the claim; an H&P done by another physician and co-signed by the claiming physician is not sufficient. TR I/79. BSI also does not consider an emergency room assessment sufficient to document an H&P, even though IMMC does accept an emergency room assessment in lieu of an H&P for its purposes. TR I/60-62.

32. BSI will reimburse a physician for a Medicare admit if the physician performs an H&P and issues an admit order on the day after an emergency admission, even though the emergency room physician also issued an admit order at the time of admission. TR I/80-81.

33. Dr. John Hostetter, an associate of the Respondent who has had a family practice in Des Moines since

1949, and practices at IMMC, testified that he bills Medicare for an admit if he performs an H&P before the resident or surgeon does. Under such circumstances, Dr. Hostetter writes up the H&P and puts the write-up in the patient's file. TR IV/974, 975. Dr. Hostetter does not do another H&P if another doctor has already done one. TR IV/965. He does not bill Medicare for an admit if he performs the H&P in anticipation of imminent surgery. TR IV/967. He does not bill Medicare for an admit if he merely provides background information for an H&P recorded by another doctor. TR IV/976. Dr. Hostetter and the Respondent took care of each other's patients (covered) when the other was out of town or unavailable. TR IV/930. Dr. Hostetter did not bill Medicare when he covered for the Respondent, but was paid by the Respondent directly. TR IV/931, 933.

34. Dr. Homer Wichern, a retired surgeon who has been on the Board of Directors of IMMC since 1972 and was chief of staff at IMMC from 1972-1974, testified that he did an H&P as soon as he saw the patient on admission; he always saw his patients right away and never waited until the next day to do an H&P. TR IV/922, 923. He said he usually did not write his H&P on the chart, because "it was [the resident's] responsibility and his job to . . . get it in the chart." TR IV/919, 920. If it was an emergency, such as the patient going right to the operating room, Dr. Wichern would write down any H&P which he had done. TR IV/920.

35. Dr. Lester Beachy, a general practitioner (GP) and associate of the Respondent's since 1971, testified that he and the Respondent had covered for each other ("traded calls") since 1971. TR IV/981, 984. He said they had a flexible arrangement, sometimes swapping services and sometimes paying each other. TR IV/985, 986. He noted that an emergency room assessment might be adequate for the H&P required for an admit, but said he would not bill Medicare for an admit of one of his nursing home patients if the emergency room doctor performed and billed for the admit. TR IV/994, 995, 998.

36. Fifty of the claims, listing 295 services at issue, were submitted on a HCFA 1500. I.G. Ex 1A-5A, 7A-9A, 12A-18A, 19A2, 20A-38A, 40A-44A, 45A1, 45A2, 46A-48A, 50A, 51A1, 51A2, 52A. By signing the HCFA 1500, the Respondent certified that:

> (1) the services listed . . . were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction; (2) the charges for such services are just, unpaid, actually due according to law and program policy and not in excess of regular fees; (3) the information provided on . . . this claim is true, accurate and complete . . . .

I.G. Ex 86B; TR I/132-133. By using Form 1500, the Respondent also specifically agreed to "keep such records as are necessary to disclose fully the extent of services provided . . . and to furnish information regarding any payments claimed for providing such services as the State Agency, its designee, or Health and Human Services may request...." Id.

37. Two of the claims, listing seven services at issue, were filed on a HCFA 1490. I.G. Ex 6A, 49A. By signing the HCFA 1490, the Respondent certified "that the services shown on the . . . form were medically indicated and necessary for the health of the patient" and "further . . . that these services were personally rendered by [him] or were rendered incident to [his] professional service by his employee under immediate personal supervision, i.e., none of the services listed on [the] form were performed by another person not in [his] employ or by an organization except as noted in item 13" (a block near the signature block, item 8). I.G. Ex 86A; TR I/134-135.

38. One claim, listing seven services at issue, was signed by the Respondent and submitted on a Deere & Company Medical Claim form attached to an unsigned HCFA 1490U. I.G. Ex 39A. The record does not show that there was a certification on the HCFA 1490U or the Deere & Company form.

39. Patients admitted to an internal medicine teaching area at the IMMC can only be admitted by physicians on the internal medicine faculty. The faculty directly supervises the residents who provide care to those patients, writing orders and managing the patients. TR II/374, 376; I.G. Ex 68.

40. The Respondent never was a member of the internal medicine faculty at the IMMC. TR II/375.

41. If a GP chooses to have a patient admitted to the care of the internal medicine teaching service at the IMMC, the GP relinquishes the hospital care of the patient to a resident, under the supervision of a member of the internal medicine faculty. TR II/376, 377, 378, 400; I.G. Ex 68. If the GP does visit the patient, it is in the nature of a social call, to show the patient that the GP is interested in how he or she is doing. TR II/378.

42. If a GP has a patient admitted to the care of the internal medicine teaching service, the resident writes the orders for the care of the patient, and the GP does not write orders or supervise the resident. TR II/377, 412.

43. A GP may resume care of a patient at will. When the GP resumes the care of the patient, the teaching service is no longer responsible for the care of the patient and orders are then written by the GP and not the resident. TR II/400, 412.

44. If a patient is admitted at the IMMC through the emergency room (ER), the emergency room physician will try to contact the GP before arranging for the patient to be placed in the care of the teaching service. TR II/409.

45. Most GP's who have patients at the IMMC do not request that the patients be placed in the care of the teaching service, or allow those in the care of the teaching service to remain there, but the internal medicine teaching service faculty serves as consultants in most of the non-teaching service cases. TR II/408, 413. In the non-teaching service cases, the GP writes the H&P. TR II/416.

46. In the opinion and experience of the physician in charge of the teaching service at the IMMC, the Respondent typically did not get directly involved in the care of an acutely ill nursing home patient of his who was received at the IMMC through the ER. TR II/415. The teaching service would provide care to those patients. Id.

47. A group of physicians incorporated as Central Iowa Medical, P.C. (CIM), contracted with the IMMC to provide medical care and staff the ER. The group consisted of Dr. Gustofson, its chief; and Drs. Bratkiewicz, Lung, Tvedte, and Wall. TR II/330-331.

48. When a patient who had been under the care of the Respondent or another GP was admitted to the IMMC through the ER, the CIM physician typically would write an evaluation of the patient's condition and the order to start treatment, after discussing the patient with the Respondent or other GP on the telephone. TR II/333-334.

49. The Respondent's standing order to CIM physicians in the ER was for them to examine and treat his patients and call him only if necessary. TR II/335-336.

50. A GP who had a patient admitted to the IMMC through the ER was expected to write an H&P and enter it in the patient's file in addition to the assessment written by the emergency room physician. TR II/341.

51. The CIM physicians typically billed Medicare for writing the emergency room assessment of the patient at the time of admission and any other medical services provided by the CIM physicians. TR II/348.

52. A GP who had a patient that needed surgery might refer that patient to a surgeon on the staff at IMMC; IMMC has had a surgical teaching service since 1946. TR II/445. If the surgeon concurs with the family practitioner, the surgeon has the patient admitted to IMMC and does the H&P, the surgical orders, the surgery, and the follow-up care. TR II/447, 448. The surgical resident usually does the initial H&P, and participates in the care of the patient; the surgeon approves and signs the H&P and supervises the resident. TR II/448, I.G. Ex 67 B.

53. The GP may also perform an H&P and write orders on a surgical patient, but this is rarely done. TR II/449. The GP may also participate in the care of a surgical patient. I.G. Ex 67 B, TR II/448. The GP never supervises a surgical resident, except through the surgeon. TR II/449.

54. Medicare allows a surgeon a single "global" fee which covers the surgery, post surgical hospital care, and, in some instances, the admitting H&P. TR I/151, 166-167; TR II/458-459, 925.

55. As the carrier for the Medicare program in Iowa, BSI acts as the agent of the Secretary, determining the rates and amounts of payment for covered services and processing and paying claims. 42 U.S.C. Section 1395u.

56. The cost of services rendered to Medicare recipients by physicians is reimburseable only if "reasonable and necessary for the diagnosis or treatment of illness or injury." 42 U.S.C. Section 1395y(a)(1)(A).

57. It has been a Medicare requirement, since July 1981, that a physician have good medical record documentation to substantiate that services billed to the Medicare program were provided. I.G. Ex 64 B/1. It has been a Medicare requirement, since May 1982, that a physician document that the services are medically necessary. I.G. Ex 64C/1,2.

58. It has been a Medicare requirement, since July 1981, that in a situation in which one physician provides medical services to the patients of another physician because the latter physician is on vacation or otherwise unavailable (i.e., one covers for the other) the substitute, or covering, physician should bill Medicare for the services provided. The absent, or covered, physician is not allowed to bill for medical care visits by the covering physician. I.G. Ex 64 B/4.

59. Two Hundred Sixty-Two (262) of the services listed on the claims at issue are coded 9024, which designates a routine hospital visit (visit). BSI defines a code 9024 service as "[e]ach day, hospital subsequent care requiring brief service." I.G. Ex 64 A/2.

60. A claim for a code 9024 service meant that the physician had seen the patient and documented the visit by an annotation in the record as to what medications should be given or medical procedures employed, or by a progress note. TR I/140, 146-147. From at least May 1982 forward, a telephone order did not constitute documentation for a visit. TR I/147; I.G. Ex 64 C/1.

61. If a physician claimed a code 9024 visit for each day of a multi-day hospital stay, he was expected to document his claims by a progress note each day. It is good medical practice for a physician providing medical services to document hospital records at least every third day, depending on the severity of the patient's condition. TR I/68, 140, 198, 229; TR II/368-371, 390, 391, 508, 509.

62. Seven of the services in the claims at issue are coded 9072, which is an intensive care or cardiac care visit. I.G. Ex 64 A/2.

63. Two of the services in the claims at issue are coded 0610, which is a limited emergency service. BSI defines a code 0610 service as "[a] level of service requiring the evaluation and treatment of an accidental injury or medical emergency (life-threatening illness) without the need for a complete examination or evaluation, and usually provided in 15 minutes or less." I.G. Ex 64 A/3; TR I/141.

64. With regard to all the hospital admits at issue (38 admit services listed on 37 claims), the Respondent "knew" or "had reason to know" that the hospital admit services "were not provided as claimed." The Respondent "knew" or "had reason to know" that there was no proper documentation as required by Medicare to evidence the 38 admit services at issue. These admits "were not provided as claimed" because:

    A. In 18 instances there was no H&P. I.G. Ex 2B1, 2B2, 6B, 13B, 14B, 26B,29B, 30B, 37B, 38B, 40B, 41B, 42B, 46B, 47B, 48B, 49B, 50B.

    B. In 19 instances the H&P, if adequate for Medicare purposes, was not done by the Respondent. I.G. Ex 1B, 3B, 5B, 12B, 16B, 17B1, 20B, 21B, 22B, 23B, 25B, 27B, 28B, 32B, 33B, 34B, 35B, 36B, 39B.

    C. In the remaining instance, the H&P was not adequate for Medicare purposes. I.G. Ex 31B. The Respondent testified that a document labelled "discharge summary" dictated by the Respondent on August 9, 1983 for a July 3, 1983 admit was an H&P. TR V/1347; TR II/362; I.G. Ex 31B. IMMC would have accepted it as an H&P. TR I/193. However, it lacked an initial treatment order. An emergency room report by a Dr. Lund contained an initial treatment order, indicating Dr. Lund admitted the patient. TR II/348; I.G. Ex 31B. The Respondent counter-signed a second July 3, 1983 "Physician Order" by another doctor. I.G. Ex 31B. None of these adequately document a Medicare admit billed July 4, 1983 by the Respondent, but his involvement is sufficient to constitute a mitigating circumstance.

65. The following are additional mitigating circumstances with regard to the 38 admits at issue:

A. In 12 admits the Respondent provided information to, or discussed his patient with, the admitting physician. TR V/1232-1233, 1259, 1289, 1293-1294, 1297-1299; TR VI/1472, 1476, 1482-1484, 1488, 1490, 1511, 1516-1517; I.G. Ex 2B1, 14B, 38B, 39B, 41B, 42B, 47B; R Ex 79C.

B. In one admit, Dr. Beachy, while covering for the Respondent when he was out of town, provided information to the emergency room physician for the emergency room assessment. TR VI/1503; I.G. Ex 46B.

66. It is an aggravating circumstance that the Respondent billed for an admit when he was out of town and Dr. Beachy, who was covering for him, wrote in the patient's chart that Dr. Beachy did not see the patient. I.G. Ex 30B; TR II/460; TR IV/1001; TR V/1346.

67. It is an aggravating circumstance that the Respondent altered the medical records of Loren Cochran, Delores Davis, and Florence Jackson after learning that these files were being investigated by the I.G. TR V/1312, 1313; I.G. Ex 17B1, 17D; TR V/1331, 1332; I.G. Ex 22B, 22D; TR VI/1456; I.G. Ex 33B, 33D.

68. Beginning May 1982 and at least through the end of the period in this case, BSI instructed providers that it would reimburse for related concurrent care only under certain conditions. BSI defined related concurrent care as "two or more physicians treat[ing] a patient for the same or similar condition which requires the skill of multiple physicians." I.G. Ex 64C/5. BSI advised providers that it would reimburse for related concurrent care:

> only when it can be determined that:
>
> 1. the patient's condition requires the services of more than one physician on an attending rather than a consultative basis, and
>
> 2. the individual services provided by each physician are reasonable and medically necessary for the patient's condition.

Id. Unrelated concurrent care for separate and distinct conditions "would normally be payable by Medicare." Id.

69. As of October 4, 1982, the medical record of Donald Atchison's hospitalization from August 25 through 30 and September 1 through 3, 1982 did not contain acceptable documentation of any medical services provided by the Respondent. There were no Progress Notes by the Respondent, and the nurses' Structured Flow Sheets did not reflect any visits by the Respondent. The only Physician's Order by the Respondent was a telephone order on September 3, 1982. I.G. Ex 4B1. A telephone order does not constitute adequate documentation of a billable visit. I.G. Ex 64C/1.

70. The Respondent certified on October 4, 1982 that he had provided nine procedure code 9024 hospital visit services (visits) to Donald Atchison, from August 25 through 30 and September 1 through 3, 1982. I.G. Ex 4A.

71. The Respondent "knew" or "had reason to know" that he "had not provided" these nine visits to Donald Atchison "as claimed."

72. On an unspecified date, probably in 1984, the Respondent altered the medical record of Donald Atchison's August 23 through September 5, 1982 hospital stay to reflect the entry of Progress Notes by the Respondent on August 25 and 27, 1982. I.G. Ex 4D1/16, 17. Mr. Atchison's medical record also was altered to reflect the entry of the Respondent's name in the Structured Flow Sheets as having visited Mr. Atchison on August 26, 27, 29, 30, and September 1, 1982. I.G. Ex 4D1/11, 12; TR III/642-646.

73. It is an aggravating circumstance that the Respondent altered the medical record of Donald Atchison after learning that it was one of the files being investigated by the I.G. TR V/1245.

74. It is a mitigating circumstance that the Respondent testified credibly, convincingly, and in detail that he did make routine hospital visits to Donald Atchison on August 25 and 27, 1982. TR V/1246-1252.

75. The medical record of Donald Atchison's hospitalization from November 17 through December 15, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders by the Respondent, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 5B.

76. The Respondent certified on January 7, 1983 that he provided 29 procedure code 9024 hospital visit services (visits) to Donald Atchison from November 17 through December 15, 1982. I.G. Ex 5A.

77. The Respondent "knew" or "had reason to know" that he "had not provided" these 29 visits to Donald Atchison "as claimed;" the Respondent was reimbursed by Medicare for these claimed services. I.G. Ex 5C.

78. The medical record of Filomena Baratta's hopitalization on October 3, 4, 5, 7, 11, and 12, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders by the Respondent, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 7B.

79. The Respondent certified on October 21, 1982 that he provided six procedure code 9024 hospital visit services (visits) to Filomena Baratta, on October 3, 4, 5, 7, 11, and 12, 1982. I.G. Ex 7A.

80. The Respondent "knew" or "had reason to know" that he "had not provided" these six visits to Filomena Baratta "as claimed."

81. It is a mitigating circumstance that the Respondent testified credibly and convincingly that he did make routine hospital visits to Filomena Baratta on October 3, 4, 5, 7, 11, and 12, 1982. TR V/1265.

82. The medical record of Gladys Beattie's hospitalization from August 22 through 24, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders by the Respondent, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 8B.

83. The Respondent certified on September 2, 1982, that he provided one procedure code 0610 emergency evaluation and treatment service to Gladys Beattie on

August 22, 1982; one procedure code 9072 intensive care unit service (ICU visit) to Gladys Beattie on August 23, 1982; and one procedure code 9024 hospital visit service (visit) to Gladys Beattie on August 24, 1982. I.G. Ex 8A.

84. The Respondent "knew" or "had reason to know" that he "had not provided" these three services to Gladys Beattie "as claimed."

85. It is a mitigating circumstance that the Respondent testified credibly, convincingly, and in detail that he provided the services at issue to Gladys Beattie on August 22, 23, and 24, 1982. TR III/76-773; TR V/1265-1268; TR VI/1612.

86. The medical record of Mary Bunte's hospitalization on January 14, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, and 27 does not contain documentation of any services provided by the Respondent. There are no Progress Notes or Physician's Orders by the Respondent, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 9B.

87. The Respondent certified on February 1, 1982 that he provided 12 procedure code 9024 hospital visit services (visits) to Mary Bunte, on January 14, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, and 27, 1982. I.G. Ex 9A.

88. The IG did not prove by a preponderance of the evidence that the Respondent "knew" or "had reason to know" that he "had not provided" these 12 visits to Mary Bunte "as claimed." The Respondent testified credibly and convincingly that he visited Mary Bunte on the dates at issue. TR V/1276. Ms. Bunte's medical record contains documentation that the Respondent visited her on January 15, 21, and 28, 1982. I.G. Ex 9B. The evidence in this case is that the Medicare requirement that a physician document each visit during a multi-day hospital stay was promulgated in May 1982, subsequent to the February 1, 1982 claim at issue. I.G. Ex 64C.

89. The medical record of William Bystrom's hospitalization from July 18 through 30 and on August 1, 1982 does not contain acceptable documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 12B. The

Respondent was out of town from July 20 through 25, 1982 and the physician covering for him did not visit Mr. Bystrom. I.G. Ex 76; TR IV/1012.

90. The Respondent certified on August 27, 1982 that he provided 14 procedure code 9024 hospital visit services (visits) to William Bystrom, from July 18 through 30 and on August 1, 1982. I.G. Ex 12A.

91. The Respondent "knew" or "had reason to know" that he "had not provided" these 14 visits to William Bystrom "as claimed."

92. The medical record of Wilma Cartwright's hospitalization on November 27, 28, 29, 30, and December 1, 2, and 4, 1981 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 15B.

93. The Respondent certified on an undated HCFA 1500 that he provided seven procedure code 9024 hospital visit services (visits) to Wilma Cartwright, on November 27, 28, 29, 30, and December 1, 2, and 4, 1981. I.G. Ex 15A.

94. The Respondent "knew" or "had reason to know" that he "had not provided" these seven visits to Wilma Cartwright "as claimed."

95. The medical record of Loren Cochran's hospitalization on November 6, 7, 8, 10 through 19, 25 through 30, and on December 1 and 2, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not relect any visits by the Respondent. I.G. Ex 17B1, 17B2. The Respondent was out of town on November 13, 14, and 15, 1982, and the physician covering for him did not provide any services. I.G. Ex 74/6; TR IV/1009.

96. The Respondent certified on January 10, 1983 that he provided 21 procedure code 9024 hospital visit services (visits) to Loren Cochran, on November 6, 7, 8, 10 through 19, 25 through 30, and on December 1 and 2, 1982. I.G. 17A.

97. The Respondent "knew" or "had reason to know" that he "had not provided" these 21 visits to Loren Cochran "as claimed."

98. It is a mitigating circumstance that the Respondent testified credibly and convincingly that he did make routine hospital visits to Loren Cochran on November 25 through 30 and December 1 and 2, 1982. TR V/1317.

99. The medical record of George Cook's hospitalization on January 21, 22, 23, 25 through 31, and on February 1, 1983 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 18B.

100. The Respondent certified on February 7, 1983, that he provided one procedure code 0610 emergency evaluation and treatment service on January 21, 1983, and ten procedure code 9024 hospital visit services (visits) to George Cook, on January 22, 23, 25 through 31, and February 1, 1983. I.G. Ex 18A.

101. The Respondent "knew" or "had reason to know" that he "had not provided" these eleven services to George Cook "as claimed."

102. It is a mitigating circumstance that the Respondent testified credibly, convincingly, and in detail that he did provide emergency evaluation and treatment services to George Cook on January 21, 1983, and did make routine hospital visits to Mr. Cook on the other dates at issue. TR V/1318-1322.

103. The medical record of Ronald Core's hospitalization from September 29 through October 7, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent I.G. Ex 19B.

104. The Respondent certified on October 6, 1982 that he provided three procedure code 9024 hospital visit services (visits) to Ronald Core, from September 29 through October 1, 1982. I.G. Ex 19A2.

105. The Respondent certified on January 10, 1983 that he provided six procedure code 9024 hospital visit

services (visits) to Ronald Core, from October 2 through 7, 1982. I.G. Ex 19A1.

106. The Respondent "knew" or "had reason to know" that he "had not provided" these nine visits to Ronald Core "as claimed."

107. It is a mitigating circumstance that the Respondent testified credibly and convincingly that he did make routine hospital visits to Ronald Core on the dates at issue. TR V/1324.

108. The medical record of Delores Davis' hospitalization from October 19 through 29, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 21B.

109. The Respondent certified on January 13, 1983 that he provided 11 procedure code 9024 hospital visit services (visits) to Delores Davis, from October 19 through 29, 1982. I.G. Ex 21A.

110. The Respondent "knew" or "had reason to know" that he "had not provided" these 11 visits to Delores Davis "as claimed."

111. The medical record of Maxine Davis' hospitalization on March 5, 6, 7, 8, and 13, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 24B.

112. The Respondent certified on March 17, 1982 that he provided five procedure code 9024 hospital visit services (visits) to Maxine Davis, on March 5, 6, 7, 8, and 13, 1982. I.G. Ex 24A.

113. The Respondent "knew" or "had reason to know" that he "had not provided" these five visits to Maxine Davis "as claimed."

114. It is a mitigating circumstance that Ms. Davis' daughter testified credibly and convincingly that Ms. Davis told her Ms. Davis had been visited by the Respondent on the days at issue. TR III/794-802.

115. The medical record of William Denson's hospitalization from August 15 through 22, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 26B.

116. The Respondent certified on October 6, 1982 that he provided eight procedure code 9024 hospital visit services (visits) to William Denson, from August 15 through 22, 1982. I.G. Ex 26A.

117. The Respondent "knew" or "had reason to know" that he "had not provided" these eight visits to William Denson "as claimed."

118. The medical record of Elias Halseide's hospitalization on January 29, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheet does not reflect a visit by the Respondent. I.G. Ex 29B. The Respondent testified that he had not gone to the hospital on January 29 until after Mr. Halseide had died. TR V/1343.

119. The Respondent certified on July 15, 1982 that he provided one procedure code 9024 hospital visit service (visit) to Elias Halseide on January 29, 1982. I.G. Ex 29A.

120. The Respondent "knew" or "had reason to know" that he "had not provided" a visit to Elias Halseide "as claimed."

121. It is an aggravating circumstance the the Respondent billed Medicare for a medically necessary hospital visit service when the Respondent knew that he had only "seen" Mr. Halseide's corpse.

122. The medical record of Florence Jackson's hospitalization from June 20 through 23, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 32B.

123. The Respondent certified on July 9, 1982 that he provided four procedure code 9024 hospital visit

services (visits) to Florence Jackson, from June 20 through 23, 1982. I.G. Ex 32A.

124. The Respondent "knew" or "had reason to know" that he "had not provided" these four visits to Florence Jackson "as claimed."

125. The medical record of Margaret Johnson's hospitalization from October 29 through November 3, 1981 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 34B. The Respondent was out of town from October 29 through November 1, 1981, and the physician covering for the Respondent testified that he did not visit Ms. Johnson. I.G. Ex 74/6; TR IV/1011.

126. The Respondent certified on January 2, 1982 that he provided six procedure code 9024 hospital visit services (visits) to Margaret Johnson, from October 29 through November 3, 1981. I.G. Ex 34A.

127. The Respondent "knew" or "had reason to know" that he "had not provided" these six visits to Margaret Johnson "as claimed."

128. It is a mitigating circumstance that the Respondent testified credibly and convincingly that he did make routine hospital visits to Margaret Johnson on November 2 and 3, 1981. TR VI/1464.

129. The medical record of Anna Jones' hospitalization from April 30 through May 10, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 35B.

130. The Respondent certified on July 9, 1982 that he provided 11 procedure code 9024 hospital visit services (visits) to Anna Jones, from April 30 through May 10, 1982. I.G. Ex 35A.

131. The Respondent "knew" or "had reason to know" that he "had not provided" these 11 visits to Anna Jones "as claimed."

132. The medical record of Anna Jones' from October 20 through 28, 1982, does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 36B.

133. The Respondent certified on January 11, 1983 that he provided nine procedure code 9024 hospital visit services (visits) to Anna Jones, from October 20 through 28, 1982. I.G. Ex 36A.

134. The Respondent "knew" or "had reason to know" that he "had not provided" these nine visits to Anna Jones "as claimed."

135. The medical record of Laura Murphy's hospitalization from November 19 through 25, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 39B.

136. The Respondent signed a Deere & Company Medical Claim on January 12, 1983, stating that he provided six procedure code 9024 hospital visit services (visits) to Laura Murphy, from November 20 through 25, 1982. I.G. Ex 39A.

137. The Respondent "knew" or "had reason to know" that he "had not provided" these six visits to Laura Murphy "as claimed."

138. It is a mitigating circumstance that the Respondent testified credibly and convincingly that he did make routine hospital visits to Laura Murphy on the dates at issue. TR VI/1479.

139. The medical record of John Parker's hospitalization on March 17, 20, 21, 22, 23 and 24, 1983 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 43B. The Respondent was out of town from March 9 through 27, 1983. I.G. Ex 76.

140. The Respondent certified on April 19, 1983 that he provided six procedure code 9024 hospital visit

services (visits) to John Parker, on March 17, 20, 21, 22, 23, and 24, 1983. I.G. Ex 43A.

141. The Respondent "knew" or "had reason to know" that he "had not provided" these six visits to John Parker "as claimed."

142. The medical record of Myrtle Pross' hospitalization from January 27 through 30, February 1 through 21, and February 23 through March 2, 1983 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 44B.

143. The Respondent certified on March 29, 1983 that he provided 33 procedure code 9024 hospital visit services (visits) to Myrtle Pross, from January 27 through 30, February 1 through 21, and February 23 through March 2, 1983. I.G. Ex 44A.

144. The Respondent "knew" or "had reason to know" that he "had not provided" these 33 visits to Myrtle Pross "as claimed."

145. It is an aggravating circumstance that the Respondent altered the medical record of Myrtle Pross after learning that it was one of the files being investigated by the IG. I.G. Ex 44D; TR I/207; TR III/713; TR V/1245.

146. The medical record of Nellie Reeser's hospitalization from April 12 through 22, 1983 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 45B.

147. The Respondent certified on April 14, 1983 that he provided one procedure code 9024 hospital visit service (visit) to Nellie Reeser on April 12, 1983. I.G. Ex 45A1.

148. The Respondent certified on July 8, 1983 that he provided ten procedure code 9024 hospital visit services (visits) to Nellie Reeser, from April 13 through 22, 1983. I.G. Ex 45A2.

149. The Respondent "knew" or "had reason to know" that he "had not provided" these 11 visits to Nellie Reeser "as claimed."

150. The medical record of Marie Siedelman's hospitalization from September 10 through 14, 1981 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 49B.

151. The Respondent certified on October 16, 1981 that he provided five procedure code 9024 hospital visit services (visits) to Marie Siedelman, from September 10 through 14, 1981. I.G. Ex 49A.

152. The I.G. did not prove by a preponderance of the evidence that the Respondent "knew" or "had reason to know" that he "had not provided" these five visits to Marie Siedelman "as claimed." The Respondent testified credibly and convincingly that he visited Marie Siedelman on the dates at issue. TR VI/1518. Ms. Siedelman's medical record contains documentation that the Respondent visited her on September 9, 1981. I.G. Ex 49B. The evidence in this case is that the Medicare requirement that a physician document each visit during a multi-day hospital stay was promulgated in May 1982, subsequent to the October 16, 1981 claim at issue. I.G. Ex 64C.

153. The medical record of Margaret Singmaster's hospitalization on September 22, 23, 24, 26 through October 1, October 3 and 4, 1982 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 51B. The Respondent was out of town on September 22, 23 and 24, 1982, and the physician who covered for the Respondent testified that he did not visit Ms. Singmaster. I.G. Ex 74/6; TR IV/1011.

154. The Respondent certified on October 11, 1982 that he provided six procedure code 9072 hospital visit services (visits) to Margaret Singmaster, on September 22, 23, 24, 26, 27, and 28, 1982. I.G. Ex 51A1.

155. The Respondent certified on October 11, 1982 that he provided three procedure code 9024 hospital visit

services (visits) to Margaret Singmaster, on September 29, 30 and October 1, 1982. I.G. Ex 51A1.

156. The Respondent certified on January 17, 1983 that he provided two procedure code 9024 hospital visit services (visits) to Margaret Singmaster, on October 3 and 4, 1982. I.G. Ex 51A2.

157. The Respondent "knew" or "had reason to know" that he "had not provided" these six I.C.U. visits and five routine hospital visits to Margaret Singmaster "as claimed."

158. It is a mitigating circumstance that the Respondent testified credibly and convincingly that he did make three I.C.U. visits and five routine hospital visits to Margaret Singmaster. TR VI/1523, 1526, 1529.

159. The medical record of Lucille Smothers' hospitalization from June 13 through 22, June 24 through 27, and June 29 through July 7, 1983 does not contain documentation of any medical services provided by the Respondent. There are no Progress Notes or Physician's Orders, and the Structured Flow Sheets do not reflect any visits by the Respondent. I.G. Ex 52B; cf. TR VI/1531, 1669.

160. The Respondent certified on August 2, 1983 that he provided 23 procedure code 9024 hospital visit services (visits) to Lucille Smothers, from June 13 through 22, June 24 through 27, and June 29 through July 7, 1983. I.G. Ex 52A.

161. The Respondent "knew" or "had reason to know" that he "had not provided" these 23 visits to Lucille Smothers "as claimed."

162. The Respondent did not prove by a preponderance of the evidence that his financial condition is a mitigating circumstance in this case.

163. It is an aggravating circumstance that the Respondent is liable under the CMPL for services claimed over a period of two years.

164. It is an aggravating circumstance that the Respondent is liable under the CMPL for claims totalling a substantial amount.

165. It is an aggravating circumstance that the claims for which the Respondent is liable under the CMPL

evidence billing practices which constitute a pattern of billing Medicare and Medicaid.

166. It is an aggravating circumstance that the Respondent is liable under the CMPL for claims which he submitted with a reckless disregard for their truth or falsity.

167. It is an aggravating circumstance that it was determined in a previous administrative proceeding that the Respondent must refund $28,619.44 in nursing home service claims, submitted during the period September 1980 through September 27, 1982, which he could not document.

168. It is an aggravating circumstance that the Respondent had a reckless disregard of Medicare billing requirements.

169. It is an aggravating circumstance that the Respondent, so as to mislead BSI, sometimes purposely put the wrong dates on his Medicare claims.

170. It is an aggravating circumstance that the Respondent testified about his retirement from the practice of medicine in such a way as to initially conceal the adverse circumstances surrounding the surrender to the Iowa Board of Medical Examiners of his license to practice medicine.

171. It is an aggravating circumstance that the Respondent billed for visits to Myrtle Pross which were neither documented nor medically necessary.

172. After weighing the aggravating and mitigating circumstances, it is appropriate, based on the evidence in this case, to impose a penalty of $67,500, an assessment of $13,000, and a suspension for three years.

DISCUSSION

Remaining at issue are fifty-three (53) claims for Medicare reimbursement listing three hundred nine (309) medical services that the Respondent declared he had provided to Medicare beneficiaries at the IMMC. All but 9 of these services are listed as an admit or a visit. See footnote 13. The Respondent does not dispute that the claims at issue were submitted between September 5, 1981 and December 16, 1983, that he presented the claims or caused them to be presented, that he signed the claims, and that he was paid by the Medicare program as a result of these claims. Stip/15.

There are only two elements of liability at issue in contention in this case. They are: (1) whether the medical services listed by the Respondent on the claims at issue were "not provided as claimed"; and (2) if "not provided as claimed," whether the Respondent "knew" or had "reason to know."

The Respondent argues that, while the medical services at issue may not have been properly documented, the services listed were, in fact, provided by him personally, provided by another physician covering for him when he was out of town, or provided pursuant to his direction and consultation. See, R Br/2. In the alternative, the Respondent argues that the proposed penalty, assessment, and suspension should be reduced. R Br/2, 3.

As outlined in detail in the Findings of Fact and Conclusions of Law and in this Discussion, I find that the I.G. proved by a preponderance of the evidence that the medical services at issue were "not provided as claimed," and, with respect to most of them, the Respondent "knew" or had "reason to know." With respect to the few remaining (i.e., seventeen (17) visits), the I.G. did not prove the above two elements of liability by a preponderance of the evidence.

Liability attaches in this case with regard to all thirty-eight (38) hospital admits at issue because the Respondent "knew" or had "reason to know" that the admits for which he billed Medicare were "not provided as claimed," in that the Medicare patients in question were, in fact, admitted to the IMMC by other physicians, and because the Respondent's input did not constitute a billable admit under the Medicare rules and requirements. The record indicates that, contrary to Medicare rules and requirements, the Respondent billed for the admits at issue when, in fact, he had not performed the essential elements of an admit

(especially the crucial element of performing a history and physical (H&P)); also, the medical records in each of these 38 admits were not properly documented by the Respondent.

Liability attaches in this case with regard to all but seventeen (17) of the two hundred sixty-two (262) hospital visits at issue because the Respondent "knew" or had "reason to know" that the visits for which he billed Medicare were "not provided as claimed," in that none of these visits were documented as required by the Medicare rules and requirements. More importantly, the preponderance of the evidence shows that most of these hospital visits were (1) not performed at all, or (2) were incomplete or insufficient under the Medicare rules and requirements. In some instances, the Respondent billed for visits when, in fact, he was out of town and the physician covering for him had not provided any billable services.

There were also two (2) emergency medical services and seven (7) ICU visits that the Respondent "knew" or had "reason to know" were "not provided as claimed." See footnote 13.

I also find that the Respondent had a reckless disregard for the Medicare rules and requirements, as well as some IMMC rules and regulations.

On the other hand, as outlined below, I find that the Respondent proved by a preponderance of the evidence some mitigating circumstances which justify reducing the amount of the proposed penalty, assessment, and suspension. The Respondent's testimony was credible and convincing at times when he recalled in specific detail that he provided some medical services to certain of the Medicare beneficiaries at issue.

For example, with regard to hospital admits, even though the Respondent did not perform the crucial element of an H&P for any of the 38 admits at issue (and, thus, these were not billable admits under the Medicare rules and requirements), the Respondent proved that he did provide some input or service in fourteen (14) of these admits.

With regard to hospital visits, even though the visits were not properly documented (and, thus, these were not billable visits), the Respondent proved that he did provide some input or service in fifty-four (54) of these visits. In other words, although the record demonstrates that none of the visits at issue was properly documented

and that the Respondent "knew" or had "reason to know" that the vast majority of the visits at issue were "not provided as claimed," I find that in fifty-four (54) instances, the Respondent provided a medical service (even though it may not have been a billable service).

Finally, it is a mitigating factor that the Respondent also provided some input or service with regard to the two (2) emergency medical services at issue and four (4) of the seven ICU visits at issue.

I. The Respondent's Billing Practices and Record Keeping, the Absence of Required Documentation, and the Respondent's Reckless Disregard for the Medicare Rules and Requirements

The Respondent, a GP, saw both private and Medicare patients. Most of the Medicare patients listed on the Medicare claims at issue in this case were institutionalized in nursing homes under the care of the Respondent, and all but one patient was hospitalized during the period at issue at the IMMC. 16/

There are three types of hospital admits and two types of hospital visits at issue. The three types of hospital admits are: emergency room (ER), surgical, and internal medicine. The two types of hospital visits are: (1) routine hospital visits when the Medicare patient was under the primary care of a surgeon or internist; and, (2) visits to patients in the intensive care unit. In some instances, contrary to the Medicare rules and requirements, the Respondent billed for both admits and visits when he was out of town and another physician was covering for him.

Each Medicare beneficiary listed on the claims at issue, with the exception of one, was admitted to a hospital and was cared for at the hospital by physicians other than the Respondent. The beneficiaries were cared for by appropriate specialists, visited at times by the Respondent, and then either discharged to the Respondent's care or

---

16/ Alice Hanlon was a patient at Northwest Community Hospital. See, I.G. Ex 30B. The I.G. alleged that the Respondent "knew" or "had reason to know" that this admit for which the Respondent billed Medicare, "was not provided as claimed" because Dr. Beachy, who was covering for the Respondent while he was out of town, did not admit the patient and wrote in the patient's chart that Dr. Beachy did not see the patient. I.G. Ex 30B.

returned to the nursing homes from which they had come. Although they were admitted and cared for by other physicians, the IMMC also considered them to be the Respondent's patients since he was their GP. His name was usually listed in the IMMC medical record as the admitting or referring physician. The Respondent made sure that all of his patients were listed on the IMMC "computer list," which was updated daily by the IMMC and made available to all physicians daily so as to assist them in keeping track of their hospitalized patients. TR I/199. 17/

A. The Respondent's Billing Practices

The Respondent's standard practice was to bill the Medicare program for an admit every time one of his Medicare patients was admitted to the hospital, whether or not the Respondent personally admitted the patient. The Respondent argues that he provided the essential elements of an admit because he consulted with and directed whatever physician might be personally present when the patient arrived at the hospital and that he performed the essential elements of an admit himself a day or two later. R Br/2.

The Respondent's standard practice was also to bill Medicare for a hospital visit for each day of hospitalization subsequent to the initial admit, until the Medicare patient was discharged. Pursuant to the Respondent's instructions, his billing clerks billed for each day that a Medicare patient was hospitalized, until the Respondent told them that the patient had been discharged. TR VI/1583. The Respondent testified that:

> Once somebody was admitted it [the billing] was an ongoing thing until they went home. And I could just say [to my office staff] so-and-so's still there, . . . so-and-so went home today . . . this is her last day. TR VI/1583.

During the period at issue, in order for a medical provider to claim Medicare reimbursement, a physician was required to document in the medical record any services rendered and (after May 1982) to state the medical necessity of such services. I.G. Ex 64B/1; I.G. Ex 64C/1; see, e.g., TR I/140. The Respondent billed Medicare for

---

17/ The "computer list" is a 3 x 5 card printed and distributed to physicians daily by the IMMC. The card lists, by doctor, the name and location in the hospital of each patient. TR I/199.

the hospital admits and the daily visits at issue here absent the required documentation in the patient's medical record.

At the IMMC, standard documentation in the hospital medical record consists of several components, including: a written H&P (IMMC requires this to be in the medical record within 48 hours after admission); physician orders; physician progress notes; and a structured flow sheet, kept by the nurses, which was supposed to record physician visits to patients. TR I/179-184. The medical record documents the progress of the patient, serves as a communication tool among doctors and nurses, and serves as the basis for planning the treatment of the patient. See, TR I/184; I.G. Ex 65.

B. The Absence of Documentation of the Medical Services at Issue Contrasted with the Respondent's Documentation of Other Medical Services

There is credible evidence that the Respondent ordinarily was conscientious about documenting services that he rendered to hospitalized patients. In contrast, the Respondent did not document the services for which he is liable in this case. For example, on 38 occasions he submitted claims for an admit, but he did not document the necessary H&P. In many instances involving the claims at issue, he billed for periods of from one to four weeks of consecutive daily visits without documenting that he had provided any services. See, e.g., I.G. Ex 5B, 12B, 17B, 21B, 35B, 44B, 45B, 52B. In one instance, he billed Medicare for 34 consecutive daily hospital visits, but documented only one visit with a progress note. I.G. Ex 44B.

The Respondent argues that the reason for this was that he was careful to document medical services rendered when the patient was under his sole care, and when other physicians (surgeons, internists and residents) were involved in the care of the Respondent's patients, he saw no need for duplicating other physicians'documentation. R Rep Br/4. This argument is not convincing; it contradicts credible testimony that such a practice is either a bad medical practice or an indication that no medically necessary service was performed.

C. The Respondent's Record Keeping

The Respondent supplied all the information that generated the Medicare claims at issue. The Respondent testified that he kept a ledger (which he called his "Day Book") in

which he recorded services he had provided. TR IV/1030. The Respondent's office staff used the Day Book when billing Medicare. The Respondent had no explanation for the fact that there were claims submitted to Medicare for visits that were not noted in the Day Book. TR VI/1579-1580, 1589-1592, 1614-1616, 1646-1647, 1651, 1653.

The Respondent testified that he based his Day Book entries on the IMMC "computer list" (showing his hospitalized patients). TR IV/1030; TR VI/1578. He stated that a mistake on the computer list might have been reflected as a billing mistake. TR VI/1616, 1647.

This testimony is not convincing. It does not explain why claims were submitted for visits not listed in the Day Book; the Respondent's billing clerks had no records other than the Day Book when preparing the Medicare claims at issue. The Respondent said he "didn't know" where his staff would have gotten billing information other than from the Day Book. TR VI/1036, 1580.

D. The Respondent's Reckless Disregard for the Medicare Rules and Requirements

The evidence in the record establishes that the Respondent recklessly and flagrantly disregarded Medicare rules and requirements. The Respondent billed for all visits that he made to Medicare beneficiaries, whether or not he documented any medical service. He billed for visits when the patient was asleep or dead. TR VI/1666-1667, TR V/1343. He billed when all of the patient's medical care was being managed by surgeons, internists, cardiologists, and residents. He billed for the kinds of visits that his colleagues considered "social calls." TR IV/963, 1000.

The Respondent argues that he provided medical care to patients suffering from multiple medical conditions and that he made visits to treat them for one condition while they were being treated for another condition by a specialist in the hospital. R Rep Br/4. The evidence supports this argument only in some instances.

The Respondent frequently billed Medicare for incorrect dates of services. He routinely represented on his claim forms that he had done an admit on the day the person was admitted, even if he did not actually do "a complete work-up" until one or two days later. TR VI/1602. He rearranged dates of service to avoid getting "flak" from BSI. TR VI/1602. The Respondent said that he considered billing for the wrong day to be "just one of those paper technicalities." TR VI/1484.

The Respondent's disregard for billing accuracy is most clearly illustrated by the Respondent's claims for hospital visits when he was out of town. The Respondent's practice was to bill Medicare on the assumption that when one of his patients was admitted to IMMC while he was away, the doctor covering for him would have done an H&P, admitted the patient, and made routine hospital visits each day after the initial admission. The Respondent was extremely negligent in that he did not even ask his colleague for the details of the services provided. TR IV/1076. In one instance where Dr. Beachy, a physician who frequently covered for the Respondent, specifically wrote in the chart that he did not admit the patient, the Respondent nevertheless "assumed" that Dr. Beachy did admit the patient and billed Medicare for an admit. TR V/1345-1347; I.G. Ex 30B/2. The Respondent agreed that errors were made. He stated that: "there were some mistakes, because this was kind of a loose arrangement," and that "it may not have been 100 percent accurate, but this is the way we did it." TR IV/1077; TR VI/1649.

II. The State and Federal Investigations of the Respondent

A. The State Medicaid Investigation

In the spring of 1982, the Office of Investigations of the Iowa Department of Human Services (IDHS) audited the Respondent's medical records at six nursing homes. TR II/420-421. This audit concluded that the Respondent was submitting claims for substantial numbers of services which were not documented, that he was billing for medical orders given over the telephone (not reimbursable by Medicaid), and that he was billing for single visits to nursing home patients when he was actually making congregate visits. See, I.G. Ex 78A/3-4, 78B/3-6; TR I/136-137, II/422. BSI was notified because the patients were also covered under Medicare. TR II/423; I.G. Ex 78D; I.G. Ex 78A/1. The county attorney declined to prosecute. See, R Rep Br/50. The case was settled and the Respondent repaid $10,794.90 which he had claimed from Medicaid. The Respondent did not admit any guilt by this settlement. Stip/10; TR II/427-429; IG Ex 78C/4, 5.

The State Medicaid investigation is irrelevant to the specific claims at issue; it is relevant only to illustrate the evolution of this case, the Respondent's general disregard for program rules and requirements, and the Respondent's poor practices regarding documentation.

B. The Investigations by BSI and the I.G.

In 1982, BSI concluded that approximately two-thirds of the hospital services and two-thirds of the nursing home services billed by the Respondent were non-reimbursable. I.G. Ex 78A; TR I/38 to 42. At the end of 1983, BSI referred the matter to Frank Kram, an investigator for the I.G. See, I.G. Ex 79B; TR I/44-45.

In 1984, Mr. Kram asked BSI to expand the audit of hospital services; BSI found that about 3/4 of the hospital admits did not have an H&P or admission orders by the Respondent, and that about half of the visits billed by the Respondent were not documented. I.G. Ex 79C. Later, Mr. Kram found that the Respondent billed for visits when the Respondent was out of town. TR III/702, 717-718; TR I/50. Mr. Kram instructed the Health Care Financing Administration (HCFA) to suspend future Medicaid payments to the Respondent (TR I/51; TR III/703; I.G. Ex 80) and instructed BSI to proceed with the recovery of the nursing home services overpayment. 18/

Based upon the BSI audit findings, as well as his own investigation and analysis, Mr. Kram concluded that the Respondent provided little or no medical care to most Medicare patients when the Respondent was not the primary care or solo care physician. Mr. Kram also concluded that the Respondent rarely wrote progress notes or orders, did not do H&P's, and was rarely listed on the nurses' Structured Flow Sheet. In contrast, when the Respondent actually admitted a patient himself and was the primary care or solo care physician, he did do an H&P, wrote progress notes and orders on a regular basis, was regularly listed on the nurses' Structured Flow Sheet, and legitimately billed for the services. TR III/713-716. Mr. Kram concluded that the Respondent's pattern of billing Medicare without any documentation and billing for admits when another physician did the H&P was fraudulent

---

18/ BSI assessed Dr. Kern an overpayment of $63,213.75. After a hearing, it was determined that the total overpayment assessed should be $28,619.44, plus interest. I.G. Ex 77.

billing. TR III/718-722. 19/ Based on these findings and conclusions, the I.G. issued its Notice in this case.

III. The Hospital Admits at Issue Were Not Provided by the Respondent as Claimed

A service is not provided as claimed unless all of the essential elements of that service are provided in accordance with the Medicare rules and requirements. For example, the procedure code for an admit (9020 or 90220) requires the physician to (1) perform an H&P, (2) initiate a diagnostic and treatment program, and (3) prepare hospital records. If all of those elements are not performed personally by the physician claiming Medicare reimbursement, the service is considered "not provided as claimed" within the meaning of the CMPL and regulations.

Thirty-eight (38) of the 309 medical services at issue (involving 37 of the 53 claims) are hospital admits. With regard to each of the 38 hospital admits at issue, the Respondent billed for an admit (Procedure Code 9020 or 90220) even though he did not personally perform an H&P in the hospital. This was in violation of Medicare requirements outlined in the Medicare Manual; as stated earlier, a physician must perform an H&P in order to legitimately bill for an admit. I.G. Ex 64A; TR I/138-140. The Respondent billed for an admit when the H&P had been done by an ER physician, a surgeon, an internist, or a resident. TR IV/1071. The Respondent argues that he performed the admits as claimed because he performed H&P's in the nursing home the day before many of the admits at issue, he participated in some of the admits by giving instructions or pertinent information to the admitting physician over the telephone, or he did a separate H&P a day or so after his Medicare patient was admitted to the IMMC.

19/ Mr. Kram also concluded that the Respondent had falsified medical records after the I.G. had begun its investigation. Mr. Kram discovered that BSI had reviewed the same medical record during two audits at least 1-1/2 years apart (I.G. 4B.1 and 4D.1) and had prepared a summary sheet of the records each time. Mr. Kram noticed discrepancies between the two summary sheets. See, I.G. Ex 4B.2 and 4D.2; TR I/84; TR III/708. He found one altered record, and then went back to IMMC in July, 1986, to review additional records and found four additional altered records. I.G. Ex 17D, 22D, 33D, 44D.

Dr. Hostettler, one of the GP's who covered for the Respondent, testified that he always documented H&P's which he performed, and that he would not bill for an admit unless he had done his own H&P before the specialist did one. TR IV/964-965, 970, 974-975. Dr. Beachy, the GP who most often covered for the Respondent, stated that he would not bill for an admit if an ER physician had done the H&P, or if he had seen the patient at the nursing home, and had not personally admitted the patient to the hospital. TR IV/994-995, 998.

The Respondent testified that he took advice on billing for admits from his friend Dr. Wichern, a surgeon to whom he often referred patients. The Respondent said that Dr. Wichern told him to bill Medicare for H&P's done by surgical residents. TR VI/1640. 20/ Dr. Wichern, however, denied getting involved in the Respondent's decisions about proper billing. TR IV/889-890.

A. Emergency Room Admits

The Respondent billed Medicare for 13 ER admits which were actually performed by an ER physician. I.G. Ex 2A.1, 14A, 26A, 29A, 31A, 37A, 38A, 40A, 41A, 42A, 46A, 47A, and 48A. During the period at issue, the Respondent rarely went to the ER to treat his patients who had been brought there. TR II/331. The Respondent instructed the physicians who staffed the ER at the IMMC to treat the patients and call him if necessary. TR II/336. Many of the Medicare beneficiaries involved in this case were brought to the ER by ambulance from nursing homes. TR II/331-332. The ER physicians admitted those patients requiring hospitalization and then contacted the Respondent by phone to let him know that the patients had been admitted, discussed an initial course of treatment, and wrote the admitting orders to cover the initial care. TR II/332-333.

In the admits at issue, the ER physicians did not usually do an H&P, but instead did either an ER "assessment" or an ER "report" (a record of care provided up to that point in time). TR II/332, 334. The ER physicians then billed Medicare for physician services provided in the ER, including the ER report. TR II/348-349. It was standard practice for the medical records staff at the IMMC to accept the ER report in lieu of a separate H&P. TR I/188.

20/ Usually, that service is included in Medicare's reimbursement to a surgeon for his surgical fee (global fee) which includes the initial hospital exam, the surgery, and post-operative hospital visits. TR I/166-167.

The Respondent often visited his patients the day after the patient was admitted and sometimes wrote a progress note in the chart at that time. TR II/340-348. The progress notes he wrote are not acceptable substitutes because they do not contain the elements essential for an admit. TR I/188-191.

The Respondent did not do H&P's or admitting orders for any of the 13 emergency room admits at issue for which he billed Medicare. TR II/339-348. The Respondent acceded that he did not do written H&P's. TR VI/1650. He stated that he thought it was proper to bill for an admit without an H&P because he did an assessment of need for hospitalization, made logistical arrangements to get the patient to the hospital, called the hospital, gave verbal information to the ER staff, planned treatment, conferred with the family, referred patients to specialists, and did the discharge summary. TR IV/1065-1071. In his view, those services could be provided by telephone rather than in person, and some of the services could be performed in the nursing home rather than in the hospital. TR IV/1071.

I find that the evidence in this case establishes that under Medicare requirements a physician could not legitimately bill for an initial hospital visit unless he personally performed an H&P.

Dr. Richard Bratkiewicz, an emergency physician at the IMMC, testified that he or other members of his group of ER physicians admitted twelve of the thirteen patients in question. TR II/339-348. In each case, the Respondent did not write an acceptable H&P, nor did he perform the other elements essential for an admit.

In some cases, the Respondent billed for a nursing home visit dated the same day or the day before a hospital admit for which he also billed. I.G. Ex 14A, 40A. He sometimes saw the patient at the nursing home, determined a need for hospitalization, and had the patient admitted through the ER without seeing the patient in the hospital on the day of admission. TR III/750.

In five of the instances in question, the Respondent billed for an admit dated the day after the patient was actually admitted. I.G. Ex 31A, 40A, 41A, 47A, and 48A. He often saw the patient the following day, but he did not document an H&P during this visit, he did not change the admitting orders, and he did not even write a comprehensive progress note.

In one instance, the Respondent billed for both an admit and a hospital visit -- two separate charges, two distinct procedure codes -- when the patient (Elias Halseide) had died the day following (some six hours after) admission to the ER. The Respondent had never come to the hospital while Mr. Halseide was alive. I.G. Ex 29B; TR II/343-344.

The Respondent argues that he came to the hospital after the patient's death to see the body and prepare a death certificate and that this justifies the claim for services. TR V/1343-1344. Neither procedure code 9020 nor procedure code 9024 apply to visits to a dead body, or to the preparation of a death certificate. By submitting claims under those two procedure codes, the Respondent represented that he had provided medically necessary medical services to a beneficiary, when in fact no medical services were provided as claimed. TR III/753.

The Respondent also billed for an admit when he was out of town and Dr. Beachy was covering for him. I.G. Ex 46A. In that instance, a patient (Lillian Roth) was admitted by an ER physician. Dr. Beachy did not do an H&P. TR II/346; TR IV/1002-1003.

B. The Surgical and Internal Medicine Admits

The Respondent claimed reimbursement from Medicare for 25 admits that were actually performed by a surgeon or internist, or a resident under the supervision of a surgeon or internist. In most of these cases, an H&P by the specialist or his resident appears in the chart. When an H&P was done by the resident, it was co-signed by the supervising specialist. I.G. Ex 67A, 68/1; TR II/449. No other co-signatures were required. TR I/204; TR IV/900-901, 995-996.

Dr. Nathan Josephson, Director of the Internal Medicine Residency Program at the IMMC, reviewed all of the records for the three internal medicine admits at issue in this case, provided an affidavit describing his findings, and testified at the hearing. I.G. Ex 68. In each case, Dr. Josephson concluded that the admit was performed by an internist or resident, not by the Respondent. One of the three patients, Danny Adams, was admitted to the teaching service; such an admission could be done only by a member of the internal medicine faculty. I.G. Ex 2B2; TR II/380-382; I.G. Ex 68/2. Another, Margaret Johnson, was seen initially in the ER, and from there was admitted to the ICU where the admitting H&P was written by a resident and co-signed by a pulmonologist who was on the hospital's teaching staff. I.G. Ex 34B; TR II/384; I.G. Ex 68/3.

The third, Marie Siedelman, was seen first in the ER and later by a gastroenterologist who admitted her to a general medical floor; the gastroenterologist's resident performed the admit. I.G. Ex 49B; TR II/385-386; I.G. Ex 68/3-4.

Dr. James A. Coil, Director of Surgical Education and head of the surgical residency program at IMMC, reviewed all of the medical records for the surgical patients at issue. He provided an affidavit describing his findings and testified at the hearing. I.G. Ex 67A. Dr. Coil concluded that none of the 23 surgical admits was performed by the Respondent as claimed.

In a number of cases, the Respondent billed for nursing home visits dated the same day or the day before the admits for which he also billed. See, I.G. Ex 1A, 4A1, 13A, 21A, 25A, 27A, 36A. The services provided by the Respondent and billed as admits were (at most) pre-admission services provided in the nursing home and not billable under procedure codes 9020 and 90220. I.G. Ex 64A/2.

The Respondent also billed for admits that he claimed were performed by Dr. Beachy when the Respondent was out of town. I.G. Ex 25A, 30A, 32A, 46A; TR V/1334-1335, 1345-1347; TR VI/1452, 1503-1504. I find Dr. Beachy's testimony that he did not do the admitting H&P in any of those instances to be credible and convincing. TR IV/1000-1005; I.G. Ex 30B/2.

IV. <u>The Hospital Visits at Issue were not Provided by the Respondent as Claimed</u>

Approximately two-thirds of the hospital visits at issue in this case are to Medicare beneficiaries under the care of a surgeon, and most of the other visits are to patients under the care of the Internal Medicine Teaching Staff at the IMMC. The Respondent billed for visits which did not meet the Medicare requirements.

As stated earlier, the Medicare rules and requirements in evidence in this case provide (as of May 1982) that every hospital visit must be supported by documentation. Documentation of a visit may include physician's orders, physician's progress notes, or nurse's notes. TR I/66. If a visit is not documented, it is "not provided as claimed" within the meaning of the CMPL and requirements. Furthermore, the Medicare rules and requirements also provide: (1) that a visit must be a "medically necessary" service (I.G. Ex 86A, 86B); (2) that a GP cannot bill for

a visit if his patient is being treated by a specialist in a hospital, unless the GP's services are required to treat a separate and distinct medical condition; and (3) that a GP cannot bill for a visit performed by a covering physician.

The Director of Medical Records at the IMMC considers the standards of practice in the medical profession to require that a progress note be made in the hospital chart at least every three days. TR I/198, 229. Dr. Bratkiewicz, a GP, testified that he would expect progress notes to be made at least every other day, and that he would expect to bill only for visits where medical care was provided and documented. TR II/368-371. Dr. Nathan Josephson, an internist, testified that daily progress notes are standard practice for a primary or covering physician. TR II/390-391. Dr. Coil, the director of surgical education at the IMMC, testified that while he had been known to make "social visits" without writing a progress note, "you are hard-pressed to bill for it." TR II/509. Two of the Respondent's witnesses, Dr. Beachy and Dr. Hostettler, both GP's, also testified that they make many "social calls" which are not documented by progress notes, and that they do not bill for such visits. TR IV/963, 1000-1007. Dr. Hostettler stated that he ordinarily makes entries in the medical records every couple of days. TR IV/955.

In contrast, the Respondent testified that he rendered medical care to patients and billed Medicare without writing progress notes or physician orders because he did not want to duplicate what a specialist had already written, because he kept poor records when he was treating a patient who was not under his sole care, and because he disliked paperwork. In one record there was not a single progress note to document claims presented for 29 consecutive days of alleged medical services. I.G. Ex 5B; TR V/1252, 1253.

On the other hand, the Respondent wrote many progress notes documenting the medical care he provided in medical records not at issue in this case. I.G. Ex 60B, 61B, 62B, 63B; TR III/633-636, 714-716. Also, the Respondent wrote progress notes regularly in one medical record (the chart of George Hess) in which the admit billed by the Respondent is at issue here. I.G. Ex 31A, 31B. These numerous notations by the Respondent contradict his assertions as to why he kept poor records when he was treating a patient not under his sole care.

A. Medicare Patients Under the Care of Surgeons

Many of the Respondent's Medicare patients whose names are listed on the claims at issue were hospitalized under the care of surgeons. The surgeons at IMMC usually had one or two residents on their service who were responsible, in conjunction with the surgeon, for the patient's care. TR II/447-448; IV/917-918. The residents normally performed and recorded the H&P under the supervision of the surgeon. TR II/448. The role of a GP in providing care to surgical patients at the IMMC was usually quite limited. GP's rarely wrote progress notes or orders or performed H&P's for patients in the surgical service. TR II/448-449. Surgical residents were never assigned to GP's and could not take direction from them. TR II/449. Surgical patients were admitted and cared for by the surgeons and their residents. While GP's could visit surgical patients, they would not normally be expected to provide any medical care to the patients. TR II/450-451.

With respect to the surgical patients whose admits and hospital visits are at issue in this case, the Respondent did not admit any of the patients, and there were few documented hospital visits. See, I.G. Ex 67A.

B. Medicare Patients Under the Care of the Internal Medicine Teaching Staff

Some of the Respondent's Medicare patients whose names are listed on the claims at issue were referred to internists for specialized care. At the IMMC, there are two ways in which a GP's patient can be seen by an internist. One is for the GP to admit the patient under his direct care and then to ask an internist to consult on the care of that patient. Most GP's at the IMMC admit patients under that arrangement and provide medical services to the patients themselves. TR II/376-377, 408. The other option is for the GP to have his patient admitted to the Internal Medicine Teaching Service. If the GP elects this option, he turns his patient over to the teaching faculty and residents. In that case, only a resident, under the supervision of an internal medicine faculty member, is to write orders for the patient and there is no medical reason for a GP to follow that patient. I.G. Ex 68. For the period of time during which the patient is on the teaching service, the GP relinquishes care of the patient to the teaching service faculty and staff. TR II/377-378. A GP is free to visit such a patient, but the visits are in the nature of social calls, not medical care. TR II/378. If at any time the GP wants to regain control over the patient's medical care, he can have the patient

removed from the teaching service, and can begin writing orders and progress notes. TR II/400.

Five of the patients whose names are listed on the claims at issue in this case were under the care of faculty internists and their residents while hospitalized at the IMMC. The Respondent did not admit any of these patients to the hospital, nor did he seek to have the patients who were placed on the teaching service removed to his care. There were few documented hospital visits by the Respondent. The visits at issue were not documented. Since these patients were under the care of the teaching service, any such visits were in the nature of social calls and not medically necessary visits, unless it was documented that the Respondent was treating these patients for a separate condition or that it was documented that it was necessary for the Respondent to assist the teaching staff. See, I.G. Ex 64C/5, I.G. Ex 68; TR II/379-390. 21/

C. Visits Performed by Another Physician When the Respondent was Out of Town

The Respondent billed Medicare for services purportedly rendered on days when, by his own admission, he was out of town. See, I.G. Ex 74/6; I.G. Ex 76; 12B, 17B1, 25B, 30B, 32B, 34B, 43B, 46B, 50B, 51B. His practice was to ask another GP to cover for him when he was away, to subsequently bill Medicare for services provided by the covering physician, and to pay the covering physician for his services by check or by reciprocating with in-kind services. TR IV/1050-1065. This practice violates Medicare requirements, which prohibit a physician from including services provided by a "covering" or substitute physician on a claim for inpatient services. I.G. Ex 64B/4.

The pertinent medical records are devoid of any documentation that services were rendered by a substitute physician on the days in question. Dr. Beachy, the physician who usually covered for the Respondent when he was out of town, testified that he did not provide most of the services at issue in this case which were billed for days when the Respondent was out of town. TR IV/1000-1012.

21/ It was the opinion of the Director of the Internal Medicine Residency Program and his colleagues that the Respondent did not want to be directly involved with the care of his acutely ill nursing home patients. TR II/415.

D. Visits For Which the I.G. Failed to Prove that the Respondent Did not Provide the Services as Claimed

The I.G. failed to prove liability with regard to 17 hospital visits at issue because the Respondent's testimony was credible and convincing that he provided the visits as claimed, despite the lack of documentation.

V. The Respondent "Knew" or Had "Reason To Know" that the Services at Issue Were Not Provided as Claimed

I held in Scott, supra, that a respondent was liable for false or improper claims of which he had "subjective" knowledge ("conscious knowledge of a fact") or "objective" knowledge (what a "reasonable man" or reasonable medical provider had "reason to know"). Scott, supra, at 27-28. The Scott Decision defines the reasonable medical provider as follows:

> Moreover, a Respondent, who is 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 Medi-Cal claims. He would have determined whether the claims he submitted to Medi-Cal were for reimbursable services and whether the services claimed were actually provided. He would have checked the claims presented against his own ledger cards to ensure that the services for which he billed Medi-Cal were actually provided on 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.

Dr. Kern did not act as a reasonable medical provider vis-a-vis the Medicare program. He purposely did not make himself familiar with the relevant Medicare rules and requirements and yet caused the claims at issue to be presented. He did not pay attention to the accuracy of his claims. In fact, he acted in reckless disregard of their accuracy. Dr. Kern, like the Respondent in the Scott case, had "reason to know" that the claims he submitted to Medicare were "not provided as claimed."

As a participant in the Medicare program since 1966, the Respondent submitted numerous claims for reimbursement to

purposely billed for the wrong day so as to make the claim look more plausible to the carrier. TR VI/1602. He clearly did not "give to his surroundings the attention which a standard reasonable man would consider necessary under the circumstances" and did not use his senses "to discover what [was] readily apparent." Scott, supra, at 27, citing Restatement of Torts (2d), section 290, Comment b.

The Respondent also "knew" that some of the services were not billable and purposely submitted false claims. For example, when a patient was admitted through the ER and died six hours later without having been seen by the Respondent, the Respondent nonetheless billed for an admit and a hospital visit, he knew that he could not possibly be entitled to be paid by Medicare for either. He testified that he was billing for viewing the body and completing a death certificate, but he was indifferent to whether the Medicare rules and requirements allowed payment for that service (TR IV/1343):

> Q.: Did you know that was not a proper billing?
> A.: No. Actually, I'm treating patients, not Medicare. . . .

To the extent that the Respondent was disdainful and ignorant of the Medicare rules and requirements, the evidence in this record demonstrates that his ignorance was self-imposed and self-serving. He simply did not care about the consequences of his disregard for the truth and accuracy of the claims he submitted. Under federal law, intent can be imputed to one who files false claims "with reckless disregard of whether the statements were true and with a conscious purpose to avoid learning the truth." U.S. v. Sarantos, 455 F.2d 877, 880 (2d Cir. 1972). Accord: U.S. v. Lange, 528 F.2d 1280 (5th Cir. 1976); U.S. v. Abrams, 427 F.2d at 86 (2d Cir. 1970); U.S. v. Jewell, 532 F.2d 697 (9th Cir. 1976), cert. denied, 96 S.Ct. 3173.

This case is unlike the Silver case, supra, in that here the Respondent had actual knowledge of the contents of the claims he submitted; he had firsthand knowledge of whether the claims he submitted reflected the services he actually provided.

There was no third-party independently responsible for the filing of the claims. There was never any allegation or evidence that the Respondent had delegated the billing process to anyone else. The Respondent's billing staff performed only the ministerial function of preparing the

BSI. The Respondent was informed about the operation of the Medicare program and was put on notice of its rules and requirements. I find the Respondent's assertion that he never received a binder entitled the "Medical Assistant's Manual" implausible. He admitted to periodically receiving bulletins called "Medicare On Record," as well as updates to the "Medical Assistant's Manual." TR IV/1026-1027; TR VII/1740. Physicians are expected to read this information so as to keep abreast of changes in Medicare rules and requirements. TR I/162-172. The updates were periodically incorporated into the manual. TR I/165-166, 171-172. The Respondent had a duty to investigate by reason of this Medicare information which put him on notice. See, pp. 7-8, Ante.

Although the Respondent, with his large Medicare practice, received billing information and instructions from BSI, he and his staff threw them away. TR VII/1740. Even bulletins pertaining to billing, procedure codes, and reimbursable services were thrown away by the Respondent's office personnel. TR VII/1741. The Respondent testified that he rarely read one of these bulletins. TR IV/1027.

Despite the Respondent's professed ignorance of the Medicare program's reimbursement rules and requirements, at the hearing he appeared to be well-informed. He understood the difference between an "assigned" and a "non-assigned" claim. TR VI/1610. He could define "congregate" and "single" nursing home visits, and the basis for billing one or the other. Id. He also understood that it was "standard procedure" to do an H&P as part of admitting a patient and billing for an admission, although he testified that he knew this because it was just "good medicine," not because it was a Medicare requirement. TR VI/1611. The Respondent was also aware of the use of different procedure codes and the charges associated with them.

Nevertheless, the Respondent chose to ignore Medicare reimbursement requirements and disregard written instructions; he chose to bill his way, not Medicare's way. He said, "I was treating the patient not the insurance company." TR VI/1604, 1605.

The Respondent clearly had access to the information he needed to file true and accurate claims. He chose to ignore the information and remain ignorant of the Medicare rules and requirements. He was unconcerned with the accuracy of his claims. He requested few, if any, details about what services were actually provided by other physicians when he was out of town. At times, he

claim forms. They did so only based on information directly provided by the Respondent. He testified that he told them how to bill and wrote the billing information in the Day Book; the Respondent's staff obtained all hospital billing information from the Day Book or from other entries made by Respondent; the staff filled out the claim forms in accordance with the Respondent's instructions. TR VI/1576-1583.

The Respondent had actual knowledge of the content of each claim and of whether his bills reflected services which he had provided. The Respondent also had actual knowledge that he had not personally provided services when he was out of town and had actual knowledge that he had not provided a written history and physical in those instances in which he billed for a hospital admission.

Moreover, the lack of documentation in the vast majority of the medical charts at issue demonstrates that either the services billed for were not medically necessary and the Respondent had "reason to know" it, or the Respondent was negligent to the patients involved for not documenting his input with regard to their care. In the latter situation, the Respondent had a pre-existing duty to provide quality care as a physician and his lack of quality care in those instances vitiates the need for independent proof to cause the duty to investigate to spring into existence. See the discussion of the "knew or had reason to know" standard of liability, pp. 5-8, Ante.

VI. The Respondent "Knew" or Had "Reason To Know" That the Services at Issue Were Not Provided as Claimed Because the Respondent Was Under a Duty to Investigate the Truth, Accuracy and Completeness of the Claims at Issue Before They Were Submitted, by Virtue of the Certification Statements on Those Claims

The Deputy Under Secretary's Opinion in Silver states that the duty to investigate the propriety of claims being submitted to Medicare or Medicaid may be triggered by pre-existing duties on the part of medical providers. A pre-existing duty is created by the certification of the claims at issue. This pre-existing duty is similar to the duty of quality care. Even if it were not a pre-existing duty, it does, at the very least, cause a duty to investigate to spring into existence under the "reason to know" standard of liability. See, Silver Opinion, p. 26. The certification on the HCFA 1500 claim form reads: "NOTICE: This is to certify that the foregoing information is true, accurate and complete."

This certification statement is present on all but four of the claims at issue in this case. All but one of the claims at issue contained the following identical certification language:

> I certify that the services shown on this form were medically necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision. . . .

The HCFA 1490 form contained substantially similar language having a similar meaning.

The certification statement is a representation that the person signing the claim has acquired sufficient information and made the requisite documentation to prove to the Medicare program that the services were provided as claimed. The Respondent was required to sign (or at least initial) the claims. In fact, he signed all of the claims at issue here. The certification statement created a duty on the Respondent to investigate the truth, accuracy, and completeness of the claims and the supporting documentation.

Certifications similar to the claims at issue are familiar to many government claim forms. In complex systems like Medicare or Medicaid, it is quite common for persons to attempt to shift responsibility for false claims to others. Those administering the program seek to affix personal responsibility for claim information on the medical provider. The certification of truth, accuracy, and completeness is a common means of gaining some reasonable assurance that the provider has attested that the claims are true, accurate, and complete.

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:

> 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, by signing the claims forms containing certification statements, was duty bound to investigate the truth, accuracy, and completeness of the claims and its underlying documentation. 22/

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

To decide the appropriate amount of the sanctions 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, (4) the financial condition of the Respondent, and (5) such other matters as justice may require. Section 1003.106(b) of the Regulations contains some general guidelines for the interpretation and application of these aggravating and mitigating factors.

While the CMPL and Regulations require consideration of aggravating and mitigating factors to determine the appropriate amount of the penalty, assessment, and

---

22/ The unqualified certification statement on the claims at issue is contrasted with certifications with qualifiers (i.e., "to the best of any knowledge and belief"). This latter type was found to impose no duty on to check the facts on 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 a different result (imposing a duty to obtain personal knowledge) if the qualifier had not been present.

suspension to be imposed in a given case, there is no formula set forth for computing them, and there is little guidance to be found in the CMPL and its legislative history (except with regard to assessments, see, 48 Fed. Reg. 38827 (Aug. 26, 1983)). The preamble to the Regulations states that "fixed numbers" have been "eliminated" as "triggering devices"; this emphasizes that discretion is preferable to a mechanical formula. 48 Fed. Reg. 38827 (Aug. 26, 1983). The preamble further 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."

The purpose of a penalty in a CMPL case is deterrence, rather than 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. 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 would prevent the wrong from being committed again by a given respondent and others.

The purpose of an assessment in a CMPL case is to enable the United States to recover the damages resulting from false or improper claims. This includes amounts paid to a respondent by the Medicare and Medicaid programs and the costs of investigating and prosecuting unlawful conduct. See 48 Fed. Reg. 38831 (Aug. 26, 1983).

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

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 a respondent's knowledge and intent. Knowledge is an

aggravating factor, and "unintentional or unrecognized error" is a mitigating factor if a respondent "took corrective steps promptly after the error was discovered." Regulations, section 1003.106(b)(2). The determination of the degree of culpability involves an inquiry into the degree of a respondent's knowledge. See, 48 Fed. Reg. 38831 (Aug. 26, 1983).

In this case, the degree of Respondent's culpability ranges from one end of the spectrum of liability to the other. At one extreme, Respondent billed for services that were "not provided as claimed" and the Respondent actually "knew" that he was submitting a false claim. At the other extreme, the Respondent had "reason to know" that billed services were "not provided as claimed" because he did not provide the essential elements of a billable service. The vast majority of the services at issue here fall in between these two extremes. It is considered an aggravating factor that the Respondent "knew" or had "reason to know" that the requisite elements of most of the service at issue were "not provided as claimed" and the Respondent "knew" or "had reason to know." It is also an aggravating factor that in some instances the I.G. proved that the Respondent "knew" that some services were not provided at all. It is a mitigating factor that in some other cases the Respondent proved that even though he had "reason to know" that the admits and visits were "not provided as claimed," he did provide some services.

There is one example worth noting. It is an aggravating circumstance that the Respondent billed for 33 visits to Myrtle Pross although he "knew" the evidence is that he never performed any medically necessary services.

Myrtle Pross was in the hospital for 52 days; she was admitted on January 26, 1983 and discharged on March 18, 1983. The Respondent did not perform or bill for an admit. He entered only one progress note, on February 22, 1983: "K+ normal. Condition essentially unchanged." He entered no physician's order. He billed Medicare for a hospital visit for each of 34 days from January 27 through March 2, 1983, except for January 31. The I.G. alleged that 33 visits were falsely claimed.

The Respondent testified that he saw Ms. Pross every day through March 2. On direct, he said that he stopped seeing her on March 2 because he "probably went out of town," but did not have Dr. Beachy or anyone else cover for him. TR VI/1497. On cross, he said that he had not seen Ms. Pross for a period of a year or a year-and-a-

half, between the time she left the nursing home and her admission to the hospital for treatment, by a surgeon, for broken bones. TR VI/1662. He noted that, while hospitalized, Ms. Pross had a number of other medical conditions which required treatment and that he treated her for all of them "as the need arose." TR VI/1664. He identified only a urinary tract infection as a condition for which he provided treatment, and he also monitored her high blood pressure and electrolyte imbalance. TR VI/1665.

Ms. Pross' son testified that he was with his mother at the hospital every day except Tuesdays from 8:30 a.m. to 8:30 p.m. and never saw the Respondent. TR II/519. The Respondent explained that he made his rounds at the hospital between 7:00 a.m. and 8:30 a.m. and always saw Myrtle Pross as one of his first patients. TR VI/1498. Geraldine Kassar, Director of Surgical Nursing at IMMC, noted that there was no entry in the nurses' notes to reflect that the Respondent had visited Ms. Pross on any of the days in question. She further stated that it "would not be probable or possible" that he could have made visits for that many days consecutively and never have been observed by the nurses on duty. TR III/641.

The evidence strongly supports a conclusion that the Respondent not only did not document visits to Ms. Pross, but that he did not even visit her on any of the days in question. Moreover, the evidence even more strongly supports the conclusion that, if he did visit, he did not provide a medically necessary service. The progress notes by the surgeon and the other physicians treating Ms. Pross indicate that she was moved to a rehabilitation unit a few days after entering the hospital and remained in the unit for the remainder of her stay. She was treated by the other physicians, including an internal medicine specialist, for the urinary tract infection and there is no indication that the Respondent was involved in treating her for this or any other condition. The other physicians continued to monitor Ms. Pross for the infection long after the Respondent, by his own admission, had stopped visiting her. Moreover, Dr. Kelley, the surgeon who operated on Ms. Pross for her broken bones, testified that medical treatment by Dr. Kern was not necessary. TR V/1218. 23/

Also, it is an aggravating circumstance that: (1) the Respondent had a reckless disregard for the Medicare

---

23/ Dr. Kelley was a witness for the Respondent.

program requirements, in that he knowingly ignored the requirements and submitted bills to Medicare for whatever he pleased; and (2) purposely indicated the wrong dates of service on claim forms to avoid getting "flak" from the carrier.

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

The guidelines, at section 1003.106(b) 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)(1) of the Regulations also state that an aggravating circumstance exists where the requests for payment were of several types, occurred over a lengthy period of time, were large in number, indicated a pattern of making such requests for payment, or the amount was substantial. Again, however, the guidelines do not indicate what period constitutes a "lengthy" period, what number of requests is a "large" number, or what amount is a "substantial" amount. See, 48 Fed. Reg. 38827 (Aug. 26, 1983). These judgments are left to the discretion of the ALJ.

Since examples of mitigating circumstances in the guideline are couched in the conjunctive, all must be proven by the Respondent in order for the nature and circumstances of the claims at issue to be considered mitigating. Here, the Respondent did not prove all of them. On the other hand, since examples of aggravating circumstances in the guidelines are couched in the disjunctive, only one need be proven by the I.G. to establish the nature and circumstances of the claims at issue to be considered aggravating. Here, the I.G. has established more than one.

The I.G. proved by a preponderance of the evidence that the Respondent billed for substantial sums ($7,400) and that the period was lengthy (over 2 years). The I.G. proved by a preponderance of the evidence that the Respondent engaged in a pattern, in this case, of making such requests for payment. The Respondent regularly and consistently billed Medicare for medical services that were not documented.

The Respondent's pattern was much broader in scope than the claims at issue. See, I.G. Ex 78B, 82B. Both the federal and state investigations of the Respondent's billing of nursing home services revealed problems. Services claimed were not documented and many visits were improperly billed as single visits when they were actually congregate visits. Other services were non-reimbursable because they were not medically necessary or were non-covered services. BSI assessed an overpayment of approximately $63,000, which the Respondent appealed. The hearing officer sustained BSI in part, finding that the Respondent had claimed $28,619.44 to which he was not entitled. I.G. Ex 77. This lack of documentation and misrepresentation of services are similar in nature to the circumstances under which the claims for hospital services at issue were presented.

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, prior to the presentation of the improper claims at issue, a respondent had been 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, subjected to actual sanctions, and the claims must not have been the subject of the instant proceeding. The preamble makes clear that prior offenses are not an aggravating circumstance, unless there has been a final agency determination or a final court adjudication. 48 Fed. Reg. 38832 (Aug. 26, 1983).

There are no "prior offenses" which could be construed as an aggravating factor in this case. While there was a prior administrative proceeding in which the Respondent was found to have been overpaid on nursing home visits, there was no finding of liability and no imposition of sanctions. See, I.G. Ex 77. It should be noted that 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).

There is only one mitigating factor: the Respondent did perform medical services in some instances.

There are two aggravating factors:

(1) The Respondent altered medical records during the course of the federal investigation. (The Respondent admits that he altered the hospital records and his explanation for doing so was that he had earlier forgotten to include the documentation of his services in those records. This is an aggravating circumstance because he made the changes knowing that there was a current investigation concerning those records, he did not inform the investigators of his changes, and he did not include the date on which he in fact made the entry.)

(2) The Respondent lacked candor at the hearing concerning the fact that the Respondent voluntarily withdrew his license to practice medicine in Iowa. (In his direct testimony, the Respondent asserted that he had surrendered his license of his own volition implying that he had decided to retire. TR IV/1022, 1564-1565. See, I.G. Br/109-110. Under intense cross-examination, however, the Respondent admitted that he turned in his license because his attorney advised him that it might be revoked if he did not, "on the basis of another situation." Id. When pressed further, he admitted that the real reason that he had surrendered his license and "retired" was that he was likely to lose his license if he did not. TR VI/1567.)

E. Financial Condition

The Regulations state that the financial condition of a respondent should 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 a respondent's financial condition. 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.

Based on the Respondent's testimony in November 1986, the Respondent has a net worth of approximately $200,000, including a Keogh plan with a net value of $107,000 after taxes; cash in his checking account, estimated at $64,000, from the sale of his house; a cash value of $14,000 in a life insurance policy; 334 shares of AT&T stock worth $8,000; a $6,500 one-third interest in an airplane; a $6,000 IRA; and two automobiles of unspecified value. The total of these amounts, not counting the automobiles, is $205,500. TR VI/1553-1562. A June 1986 financial statement, filed with the Respondent's request for hearing, listed assets totalling $246,410 (not including his IRA and his Keogh plan) and liabilities totalling $115,039.

Income tax returns for 1984 and 1985, filed along with his request for hearing, corroborate the Respondent's testimony that he pays $1,800 monthly in alimony, his principal expense. TR VI/1552. The other expenses that he testified to were not verified by any documentation and were not consistent with his financial statement. Also, his financial statement valued his automobiles at $6,000, his AT&T stock at $11,000, and listed other stocks and bonds (not mentioned in his testimony) at $88,410.

The Respondent testified that he was unemployed and likely to remain so. TR VI/1549-1550. He said that he had a monthly income of $450 plus an unspecified additional amount, from various investments (TR VI/1553); his financial statement reported a monthly income of $642. Neither figure appeared to include what income he might derive if he invested the $64,000 in his checking account, the cash value of his insurance, or the amount in his Keogh plan.

The Respondent had the burden of proving by a preponderance of the evidence that his financial condition would prevent him from being able to pay the penalty and assessment imposed in this case. Based on the above, I find that he has not met this burden.

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

The I.G. proposed a penalty of $203,925, an assessment of

$14,870, and a ten-year suspension. 24/ After weighing all of the evidence in this case (including the fact that the I.G. failed to prove liability with regard to 17 services at issue and that I dismissed four services at issue for lack of notice), and after reevaluating the penalty in light of the implications of the Respondent's culpability under the "reason to know" standard of liability, and considering all of the aggravating and mitigating circumstances, I find the proposed penalty, assessment, and suspension to be too high.

I conclude that a penalty of $67,500 is a sufficient deterrent under the circumstances of this case, that $13,000 is sufficient to compensate the Government, and a three-year suspension is sufficient for ensuring program integrity.

It should be noted that 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). Also, it should be noted that the Respondent was given the benefit of the doubt in many situations where he testified that he provided some service to the Medicare beneficiaries involved in this case, even though he did not prove that the services provided were medically necessary, much less documented and billable.

24/ The maximum penalty that could have been imposed under the CMPL and Regulations -- $616,000 -- is much greater than the amount 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).

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 $67,500.

(2) Pay an assessment of $13,000.

(3) Be suspended from Medicare and Medicaid programs for a period of three (3) years.

/s/

Charles E. Stratton
Administrative Law Judge