DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Appeals Board

Civil Remedies Division

In the Case of:	
The Inspector General,	DATE: Jan 12, 1989
- v. -	Docket No. C-40
Donald O. Bernstein, D.C.,	DECISION CR 16
Respondent.	

DECISION AND ORDER

The Respondent waived his right to a formal evidentiary hearing in this civil money penalty and assessment case and the parties jointly requested that I issue a decision and order on the basis of their stipulation of facts dated January 4, 1989.

APPLICABLE FEDERAL STATUTES AND REGULATIONS

A. Statutes

This case is governed by the Civil Monetary Penalties Law (CMPL), Section 1128A of the Social Security Act, 42 U.S.C. 1320a-7a (West U.S.C.A., 1988 Supp). The CMPL provides that any person submitting a claim for Medicare or Medicaid reimbursement for an item or service that the person knows or should know was not provided as claimed shall be subject to a civil money penalty of not more than $2,000 for each item or service, an assessment of not more than twice the amount claimed for each item or service, and exclusion from participating in Medicare and Medicaid programs. These penalties are in addition to any other penalties that may be prescribed by law.

B. The Regulations

The governing federal regulations (Regulations) are codified in 42 C.F.R. sections 1003.100 through 1003.133 (1987) and 52 Fed. Reg. 49412 (December 31, 1987). These

Regulations provide for a full and fair trial-type hearing before an Administrative Law Judge (ALJ).

BACKGROUND STATEMENT

On February 24, 1988, the Inspector General (I.G.) issued a notice of proposed determination (Notice), through the Deputy Assistant I.G. for the Civil Fraud Division, informing Donald O. Bernstein, D.C. (Respondent), that the I.G. had determined that the Respondent is subject to a penalty of $63,000 and an assessment of $3,488. The Notice alleged that the Respondent had presented or caused to be presented to Blue Shield of Florida, the designated Medicare carrier, false claims for Medicare reimbursement for 210 spinal manipulations that the Respondent knew, had reason to know, or should have known were not provided as claimed during the period January 1982 through May 28, 1982, a time when the Respondent was a practicing chiropractor in Coral Springs, Florida.

On April 26, 1988, the Respondent timely disputed the I.G.'s allegations concerning liability, argued that the penalty and assessment proposed by the I.G. are inappropriate, and raised several legal defenses.

A prehearing conference was held in Denver, Colorado on October 24, 1988, and a Prehearing Order and Notice of Hearing was issued on October 27, 1988 summarizing all matters discussed at the conference.

PREHEARING RULINGS

A. Ruling On The Respondent's Motion For Competency And Mental Status Examination

At the prehearing conference, the Respondent presented a motion to have each of the eight patients whose care and treatment are at issue in this case examined for competency and mental status. The I.G. opposed the Motion, and I denied it during the conference. The reasons I denied the Motion are: (1) the Regulations at section 10003.117(a) state that depositions are not authorized, and I determined that such examination would be in the nature of an unauthorized deposition, (2) the Respondent would be given the opportunity to cross-examine each of these witnesses at a hearing, and (3) the competency of the witnesses is something that would become apparent to me as the trier of fact at the formal hearing.

Since the Respondent waived his right to a formal evidentiary hearing, the issue is moot.

B. Ruling On The Respondent's Motion To Dismiss

In his request for a hearing, the Respondent moved to dismiss this action, arguing that the applicable statute of limitations was five years, that the subject claims for Medicare reimbursement were submitted by the Respondent more than five years preceding the date of the I.G.'s Notice, and that, in effect, the application of the new six year statute of limitations would be unconstitutional in that it would revive claims barred by the five year period of limitations. The Respondent also argued that the I.G. was allowed to bring only one civil action on the same set of facts and that since the Respondent was suspended from participation in the Medicare and Medicaid programs pursuant to another provision of the Act in 1985, the I.G. was estopped from initiating this action for a civil penalty and assessment. Finally, the Respondent argued that a 1987 agreement between him and the I.G. precluded the I.G. from bringing this action.

In response, the I.G. argued that (1) the six year statute of limitations applied in this action; (2) the claims at issue were within the applicable six year period; (3) there was no constitutional prohibition to applying the six year statute of limitations to this action; and (4) the I.G. was not estopped or precluded from proposing a civil money penalty and assessment pursuant to the CMPL merely because the Respondent was suspended under a separate provision of the Act over three years ago (section 1128 of the Act) or because of a 1987 agreement which was no longer in effect.

On September 23, 1988, I issued a ruling denying the Respondent's motion to dismiss, and concluding that the six year statute of limitations (rather than the five year period of limitations provided for in the Regulations) applied in this case. Specifically, I ruled that: (1) Congress intended that the six year statute of limitations would apply to all CMPL actions initiated after September 1, 1987; (2) this CMPL action was not precluded by the Respondent's prior suspension or by the 1987 agreement between the parties; and (3) section 1003.115(c) of the Regulations denied me the authority to determine whether the retroactive application of the six year statute of limitations to this action is a violation of the Constitution of the United States.

ISSUES

The remaining issues are:

1. Whether the I.G. proved by a preponderance of the evidence that the Respondent knew, had reason to know, or should have known that each of the Medicare services at issue was not provided as claimed by the Respondent.

2. Whether the amount of the penalty and assessment proposed by the I.G. is appropriate under the circumstances of this case.

FINDINGS OF FACT AND CONCLUSIONS OF LAW 1/2/

Having considered the entire record, the arguments and the submissions of the parties and being advised fully herein, I make the following Findings of Fact and Conclusions 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, and all other pertinent regulations of the United States. Stip. A. 1.

2. This case is governed by the CMPL and the Regulations. Stip. A. 2.

3. The Secretary had delegated to the I.G. the authority to take action under the CMPL and the Regulations, and this authority has been redelegated to the Deputy Assistant Inspector General for Civil Fraud. Stip A. 3. to 5.

4. The I.G. issued his Notice to the Respondent on February 24, 1988. Stip. B. 1.

5. The Respondent filed a timely response to the I.G.'s Notice on April 2, 1988.

1/Any part of this Decision and Order preceding and following the Findings of Fact and Conclusions of Law which is obviously a finding of fact or conclusion of law is hereby incorporated into this section.

2/All "Stip." references are to the stipulation of facts dated January 4, 1989.

6. The Respondent presented, or caused to be presented, to Blue Shield of Florida each of the claims for Medicare reimbursement listed in the Appendix to the I.G.'s February 24, 1988 Notice. Stip. B. 4.

7. The amounts claimed from the Medicare program and the amounts paid in Medicare reimbursement with respect to the claims at issue are correctly reflected in the Appendix to the February 24, 1988 Notice; as the designated Medicare carrier in Florida, Blue Shield of Florida was authorized to process and pay these claims filed by the Respondent for Medicare reimbursement. Stip. B. 2 to 5.

8. The 210 services at issue were described as "manipulations of the spine," on the HCFA 1490 claim forms presented or caused to be presented by the Respondent. On each claim form, the signed or stamped signature of 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 . . . ." Additionally, on each claim form it was certified that "x-rays proximate to course of therapy are available for review." Stip. B. 6.

9. The Respondent is in possession of no medical records, x-rays, financial information, or any other documentation pertaining to any of the 210 services at issue. Stip. B. 7.

10. On or about April 28, 1982, the Respondent presented or caused to be presented to Blue Shield of Florida a Medicare claim form seeking payment for 22 spinal manipulations rendered to Medicare beneficiary Miriam Silverstein (Medicare # 101109408B) during the period January-April 1982. If called as a witness, Mrs. Silverstein would testify, without contradiction, that she saw the Respondent on only one occasion, and that the balance of the visits and procedures specified on the claim form did not occur. Furthermore, Mrs. Silverstein would testify that at the time of her only visit to the Respondent, she was asked to sign several blank Medicare claim forms. The Respondent knew, had reason to know, or should have known that 21 of the 22 services specified on the claim form requesting Medicare reimbursement (counts 113-133) were not provided. Stip. B. 8.

11. On or about April 28, 1982, the Respondent presented or caused to be presented to Blue Shield of Florida a Medicare claim form seeking payment for 26 spinal manipulations rendered to Medicare beneficiary Fay Schwartz (Medicare # 088260190A) during the period January-April 1982. If called as a witness, Mrs. Schwartz would testify, without contradiction, that she saw the Respondent on only one occasion, May 3, 1982, and that all services for which reimbursement was sought prior to that date were not rendered. Furthermore, Mrs. Schwartz would testify that, at the time of her only visit to the Respondent, he requested that she sign a blank Medicare claim form. The Respondent knew, had reason to know, or should have known that the 26 services specified on the claim form requesting Medicare reimbursement (counts 86-111) were not provided. Stip. B. 9.

12. On or about May 27, 1982, the Respondent presented or caused to be presented to Blue Shield of Florida a Medicare claim form seeking payment for 27 spinal manipulations rendered to Medicare beneficiary Bertha Snyder (Medicare # 569091417A) during the period January-May 1982. If called upon as a witness, Mrs. Snyder would testify, without contradiction, that she did not visit the Respondent for treatment in 1982, and that all the specified services for which Medicare reimbursement was sought were not rendered. The Respondent knew, had reason to know, or should have known that the 27 services specified on the claim form requesting Medicare reimbursement (counts 162-188) were not provided. Stip. B. 10.

13. On or about May 28, 1982, the Respondent presented or caused to be presented to Blue Shield of Florida a Medicare claim form seeking payment for 22 spinal manipulations rendered to Medicare beneficiary Leonard Snyder (Medicare # 549100591A) during the period January-May 1982. On July 20, 1982, Mr. Snyder sent a letter to Blue Shield of Florida stating that "my wife and I were never in Dr. Bernstein's office . . . or did we receive any treatment from him at any time during 1982." This information would be corroborated by Mrs. Bertha Snyder who, if called upon as a witness, would testify, without contradiction, that neither she or her husband visited the Respondent for treatment in 1982, and that all the specified services for which Medicare reimbursement was sought were not rendered. The Respondent knew, had reason to know, or should have known, that eight of the services

specified on the claim form requesting Medicare reimbursement (counts 189-196) were not provided. Stip. B. 11.

14. On or about March 31, 1982, the Respondent presented or caused to be presented to Blue Shield of Florida a Medicare claim form seeking payment for 24 spinal manipulations rendered to Medicare beneficiary Nicholas St. Angelo (Medicare # 134127523A) during the period January-March 1982. If called upon as a witness, Mr. St. Angelo would testify, without contradiction, that he saw the Respondent on only three or four occasions, and that the balance of the visits and procedures specified on the claim form did not occur. Furthermore, Mr. St. Angelo would testify that, during one of his visits, he was asked to sign a blank claim form. The Respondent knew, had reason to know or should have known that 20 of the 24 services specified on the claim form requesting Medicare reimbursement (counts 5-24) were not provided. Stip. B. 12.

15. On or about April 16, 1982, the Respondent presented or caused to be presented to Blue Shield of Florida a Medicare claim form seeking payment for 14 spinal manipulations rendered to Medicare beneficiary Thomas Barber (Medicare # 111246759A) during the period January-April 1982. If called upon as a witness, Mr. Barber would testify, without contradiction, that he did not visit the Respondent for treatment in 1982 and that the specified visits and procedures did not occur. Furthermore, Mr. Barber would testify that, upon first visiting the Respondent's office in 1981, he was asked by the Respondent to sign a blank claim form. The Respondent knew, had reason to know, or should have known that the 14 services specified on the claim form submitted by the Respondent requesting Medicare reimbursement (counts 25-38) were not provided. Stip. B. 13.

16. On or about May 12, 1982, the Respondent presented or caused to be presented to Blue Shield of Florida a Medicare claim form seeking payment for 28 spinal manipulations rendered to Medicare beneficiary Carmen Murphy (Medicare # 133012456D) during the period January-May 1982. If called upon as a witness, Mrs. Murphy would testify, without contradiction, that she did not visit the Respondent for treatment in 1982 and that the specified visits and procedures did not occur. The Respondent knew, had reason to know, or should have known that the 28 services specified on

the claim form submitted by the Respondent requesting Medicare reimbursement (counts 134-161) were not provided. Stip. B. 14.

17. On or about May 26, 1982, the Respondent presented or caused to be presented to Blue Shield of Florida a Medicare claim form seeking payment for 20 spinal manipulations rendered to Medicare beneficiary Lottie Gerstel (Medicare # 334166693) during the period April-May 1982. Two other claim forms had also been previously presented by the Respondent seeking Medicare payment for services rendered on 12 prior occasions to beneficiary Lottie Gerstel in March-April 1982. If called upon as a witness, Mr. Gerstel would testify, without contradiction, that she visited the Respondent's office for treatment in 1982 no more than ten times and that she did not receive treatment from the Respondent on the 32 occasions for which reimbursement was requested. Furthermore, she would testify that she was hospitalized in May 1982 for the condition for which she initially went to the Respondent for treatment, and accordingly she could not have received services from the Respondent on the dates specified on his claim form. Medical record documentation from University Hospital in Plantation, Florida would indicate that Mrs. Gerstel was admitted to the hospital on May 18, 1982 and discharged on May 21, 1982. The Respondent knew, had reason to know, or should have known that 20 of the services specified on claim forms submitted by Respondent requesting Medicare reimbursement (counts 39-58) were not provided. Stip. B. 15.

18. Blue Shield of Florida and the Department of Health and Human Services received complaints from other Medicare beneficiaries stating that spinal manipulations as specified on the Respondent's claims for Medicare reimbursement were never rendered to them. Stip. B. 16.

19. On August 15, 1984, the Respondent was charged in an indictment handed down by a federal grand jury with violations of 18 U.S.C. 1001, 1341 and 2, involving the submission of false claims for Medicare reimbursement. He subsequently entered into a Plea Agreement wherein he agreed to plead guilty to count two of the indictment pertaining to the submission of a false Medicare claim for services allegedly rendered to beneficiary Thomas Barber. The services specified in count two correspond to counts 25-38 listed in the Appendix to the February 24, 1988 Notice. In the Plea

Agreement, the Respondent also stipulated to "mail[ing] a claim form (claim # 111246759A) to Blue Shield in Jacksonville, Florida seeking payment in the amount of $210 for visits and spinal manipulations with regard to Thomas Barber, which visits and manipulations did not occur." Stip. B. 17.

20. On May 10, 1983, the Respondent was convicted on count two of the aforementioned indictment, for violating 18 U.S.C. 1001 and 2. He was sentenced on May 10, 1985 in the U.S. District Court for the District of Colorado to three years probation, was fined $1,000, and "ordered to serve 30 days in a jail-type institution on weekends." On January 10, 1986, an Order was issued modifying the sentence to discharge "ten days of the 30 day jail sentence." The Respondent served his period of incarceration, paid his fine, and fully and completely abided by every term and condition of probation. The Respondent's probation was terminated upon successful completion in 1988. Stip. B. 17.

21. On September 30, 1985, based on the aforementioned conviction, the Respondent was suspended from participation in the Titles XVIII (Medicare) and XIX (Medicaid) programs for a period of ten years, pursuant to section 1128(a) of the Social Security Acct, 42 U.S.C. 1320a-7(a). Stip. B. 17.

22. In 1983, the Respondent relocated to Colorado, where he currently practices his profession. In 1987, as a result of the aforementioned felony plea, the Colorado State Board of Chiropractic Examiners issued to the Respondent a Letter of Admonition for his misconduct in connection with this matter. Since that date, the Respondent has conducted his practice in accordance with the rules and regulations of said Board and is in good standing in Colorado. Stip. B. 18.

23. The stipulated facts and evidence support a finding of liability with respect to 164 out of the 210 services at issue and specified in the Appendix to the I.G.'s February 24, 1988 Notice. Accordingly, the penalty and assessment in this case should be predicated only on these 164 counts. Stip. B. 19.

24. Further, the parties stipulated to the entry of judgment against the Respondent in the form of a civil money penalty of $49,200.00 and an assessment of $2,722.40. 42 U.S.C. section 1320a-7a(a); Stip. B. 19.

25. The entry of this Decision and Order, which is based upon stipulated facts and evidence, in no way precludes the parties of their appeal rights, as provided for in 42 U.S.C. 1320a-7a(e) and 42 C.F.R. 1003.125, 1003.127. Stip. B. 20.

26. The parties expressly reserved the right, upon the rendering of this Decision and Order, to preserve and pursue any appeals, and the stipulation of facts in no way limits a legal challenge to the initiation of this action by the I.G. and a legal challenge to the imposition of a civil money penalty and assessment on the Respondent. Stip. B. 20.

27. After weighing all circumstances and examining the record in this case, it is appropriate to impose a penalty of $49,200.00 and an assessment of $2,722.40 on the Respondent.

DISCUSSION

Based on the stipulation of facts executed and filed by the parties, the I.G. has proven by a preponderance of the evidence that the Respondent did know, had reason to know, or should have known that 164 Medicare claims submitted in 1982 by the Respondent were false claims for services that were not provided by the Respondent as claimed and that a penalty of $49,200.00 and an assessment of $2,722.40 is appropriate under the circumstances of this case.

While the Respondent has conceded most of the facts alleged by the I.G. in the I.G.'s February 24, 1988 Notice and has waived his right to a formal hearing, the Respondent reserved the right to appeal the legal and constitutional issues raised.

Accordingly, it is appropriate for me to enter an Order for the amount of penalty and assessment stipulated to by the parties.

ORDER

Based on the entire record, the CMPL, and the Regulations, it is hereby Ordered that the Respondent:

(1) Pay a penalty of $49,200,00; and

(2) Pay an assessment of $2,722.40

/s/

Charles E. Stratton
Administrative Law Judge