DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Grant Appeals Board

Office of Hearings for Civil Money Penalties

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| In the Matter of: | |
| The Inspector General, | DATE: Mar 14, 1986 |
| - v. - | Docket No. C-11 (Civil money penalties, assessments, and suspension proposed pursuant to §§1128A and 1128(c) of the Social Security Act) |
| Narendra Khurana, M.D., | |
| Respondent. | Decision #CR6 |

## DECISION AND ORDER

This is a civil money penalties, assessments, and suspension case arising from (1) a determination by the Inspector General (I.G.) of the Department of Health and Human Services (DHHS) that the Respondent submitted false or improper Medicare claims for payment in violation of sections 1128A and 1128(c) of the Social Security Act, as amended (42 U.S.C. §§1320a-7a and 1320a-7(c)) (Act) and their implementing federal regulations (45 C.F.R. §§101.100 et. seq.) (Regulations), and (2) a request for a hearing filed by the Respondent in accordance with section 101.109(b)(2) of the Regulations. 1/ 2/

## THE LAW AND REGULATIONS

Section 1320a-7a (§1128A) of the Act authorizes the Secretary of DHHS to determine to impose civil money penalties and assessments against any person who has presented or caused to be presented any

1/ Both sections 1128A and 1128(c) of the Social Security Act are codified in sections 1320a-7a and 1320a-7(c) of Title 42, U.S.C., and are part of section 2105 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. No. 97-35, enacted on August 13, 1981), as amended by section 137(b)(26) of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. No. 97-248). Section 1128(c) was formerly section 1128(b), and was redesignated as a result of amendments to section 1128 in the Deficit Reduction Act of 1984 (Pub. L. No. 98-369 §2333(a)(1)). All references to the Act hereinafter refer to the codified sections.

2/ The Regulations were approved on July 27, 1983, and became effective on September 26, 1983. See, 48 Fed. Reg. 38827 et seq. (August 26, 1983).

false or improper claims for payment under the Medicare, Medicaid, or the Maternal and Child Health Services Block Grant programs.

Section 1320a-7(c) (§1128(c)) of the Act authorizes the Secretary to determine to suspend from the Medicare and Medicaid programs any person against whom a civil money penalty or assessment has been imposed.

The Act provides for written notice and the opportunity for a hearing. The Regulations implement the provisions of the Act, delegate authority to the I.G. to make determinations regarding false or improper claims presented, and provide a right to a hearing before a federal administrative law judge (ALJ) to those respondents against whom the I.G. proposes civil money penalties, assessments, or a suspension. The I.G. has the burden of proof regarding liability and aggravating circumstances; a respondent has the burden of proof regarding circumstances that would justify reducing the amount of the penalty or assessment, or the period of suspension, if found liable. Regulations §101.114. Either party may seek review by the Secretary of an ALJ's decision and order and may seek judicial review of any decision and order that has become final. Regulations §§101.125, 101.127. There are differences in the Act and Regulations for claims presented to and received by the Medicare program prior to the effective date of the Act (August 13, 1981), versus claims presented and received on or after that date.

A) False Claims Presented And Received By The Medicare Program Before August 13, 1981.

For false claims presented and received prior to the effective date of the Act (i.e., August 13, 1981), the amount of the civil money penalties and assessments, and the burden of proof are governed by the provisions of the False Claims Act (31 U.S.C. §3729 et. seq.) by reason of sections 101.103, 101.104 and 101.114(b) of the Regulations. 3/ The maximum penalty is $2,000 for each false claim, the assessment is limited to twice the amount of damages sustained by the Federal Government, plus costs, and the I.G. has to prove liability by clear and convincing evidence.

Section 101.114(b) of the Regulations provides:

> (b) to the extent that a proposed penalty and

3/ The predecessor law in effect prior to August 13, 1981, was and still is, the civil False Claims Act, 31 U.S.C. §231 et. seq., (recodified and reworded slightly as §3729 on September 13, 1982); the civil False Claims Act has been in effect since 1865. The criminal portion of the False Claims Act is found at 18 U.S.C. §287 et. seq. All references in this Decision and Order are to the civil False Claims Act.

> assessment is based on claims presented before August 13, 1981, the Inspector General must prove by clear and convincing evidence that:
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> (1) the Respondent presented or caused to be presented such claims as described in §101.102 and (2) presenting or causing to be presented such claims could have rendered Respondent liable under the provisions of the False Claims Act, 31 U.S.C. 3729 et. seq., for payment of an amount not less than that proposed.

The civil False Claims Act, 31 U.S.C. §3729, authorizes:

> . . . a civil penalty of $2,000, an amount equal to 2 times the amount of damages the Government sustains . . . and costs of the civil action, if the person-
> 1) knowingly presents, or causes to be presented . . . false or fraudulent claim for payment or approval; [or]
> 2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved . . .

The Regulations implementing the Act have the force and effect of law. The Regulations provide for the retrospective application of the Act to claims filed by a respondent before the effective date of the Act (August 13, 1981). But, section 101.132 of the Regulations provides that the I.G. must commence an action (by sending a notice of determination to a respondent) within five (5) years "from the date on which the right of action occurred." This retrospective application of the Act by the Regulations is consistent with the Act because the Act's legislative history suggests that retroactive treatment be accorded. Also, the Regulations provide certain guarantees that protect respondents from overreaching. The preamble to the Regulations states:

> The ex post facto clause of the United States Constitution, Art. I, section 9, cl. 3, does not bar the retrospective application of this statute to claims filed before the Act's effective date. It is well settled that the clause pertains only to criminal statutes that make punishable conduct that was not criminal at the time it was committed, that increase the amount of punishment for past conduct, or that alter the rules of evidence to make it easier to convict a criminal defendant. Calder v. Bull, 3 U.S. (3 Dall.) 386 (1978).
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> There is some indication in the legislative history that Congress intended [the Act to be applied retrospectively].

48 Fed. Reg. 38828 (August 26, 1983).

But, even though the preamble to the Regulations states that the ex post facto clause of the United States Constitution does not bar the retrospective application of the Act and that the Act is not a criminal or penal statute, section 101.114(b) of the Regulations goes much further than the Act and the preamble and guarantees that (1) (even if the Act were deemed to be a penal statute, which it is not) the Act cannot generate penalties and assessments greater than those which could have been imposed under the predecessor statute, the False Claims Act, and (2) the I.G.'s burden of proof is the same as it would be if he were proceeding under the False Claims Act. Accordingly, the only real change the Act and Regulations make for pre-August 13, 1981 claims is a change in forum, (i.e., the case is heard by an ALJ instead of a District Court). The retroactive change of forum is consistent with (1) the rule that statutory changes that are basically procedural or remedial apply retroactively, and (2) the rule that Congress may change the tribunal from a Federal District Court to an administrative forum without violating Constitutional or substantive rights. See, United States v. Ward, 448 U.S. 498 (1980); Zenith Radio Corp. v. United States, 437 U.S. 443, 450 (1978); Atlas Roofing Co. v. Occupational Safety and Health Commission, 430 U.S. 442 (1977); Hallowell v. Commons, 239 U.S. 506, 508 (1916); United States v. J. B. Williams Co. 498 F. 2d 414, 421 (2nd Cir. 1979); see also, 29 U.S.C. §651, et. seq.

In summary, for claims presented prior to August 13, 1981, the Act and Regulations limit the amount of civil money penalties and assessments to those amounts that could have been recovered under the False Claims Act, provide the same burden of proof as does the False Claims Act, and provide for a hearing before an ALJ, rather than a proceeding in a Federal District Court.

B) False Claims Presented To And Received By The Medicare Program On Or After August 13, 1981.

For false claims presented and received on or after August 13, 1981, the maximum penalty is $2,000 for each false item or service listed on each claim, the assessment is twice the amount claimed on each claim and the I.G. must prove by a preponderance of the evidence that the Respondent presented or caused to be presented any false claims. Regulations §§101.103, 101.104, 101.114(a).

C) Suspension From Medicare and Medicaid Program Participation Is Appropriate Only If Liability For Civil Money Penalties Or Assessments Is Proven.

Suspension from program participation may seem, at first blush, to be the same for both pre and post-August 13, 1981 claims. 4/ Simply stated, suspension is never triggered unless liability for civil money penalties or assessments is found to be proven. Section 101.107 of the Regulations provides that the same factors used to determine liability and amount of liability are used to determine suspension and length of suspension. So, in order to find liability for pre-August 13, 1981 claims, the False Claims Act standard and burden of proof are used; to find liability for post-August 13, 1981 claims, a different standard and a lesser burden of proof are used. Thus, suspension based upon pre-August 13, 1981 versus post-August 13, 1981 claims is different in that differing burdens of proof apply.

D) Mitigation.

Section 101.114(d) of the Regulations provides that the Respondent shall:

> bear the burden of producing and proving by a preponderance of the evidence any circumstances . . . that would justify reducing the amount of the penalty or assessment, or the period of suspension.

This burden applies to pre-August 13, 1981 claims as well as to claims received by the Medicare program on or after August 13, 1981.

E) The Medicare Program and Reimbursement Procedures.

Title XVIII of the Act (42 U.S.C. §1395, et. seq.) establishes a program of Health Insurance for individuals who are age 65 or older or disabled persons. This program, known as Medicare, basically consists of Part A, which is not at issue in this case, and Part B, which is in issue here. 5/ Part B provides a voluntary

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4/ 42 U.S.C. §1320a-7(c) reads:

> Whenever the Secretary makes a final determination to impose a civil monetary penalty or assessment . . . . under section 1128A relating to a claim under Title XVIII [Medicare] or XIX [Medicaid], the Secretary -
> (1) may bar the person from participation in the [Medicare] program . . . and
> (2) ***may require [appropriate state agencies] to bar the person from participation in the [Medicaid] program . . .

5/ There is also a Part C of Title XVIII, 42 U.S.C. §§1395x-1395xx, which contains miscellaneous provisions applicable to the programs under both Parts A and B.

subscription program of supplementary medical insurance covering, in general, 80% of the reasonable charges for physician services, x-rays, laboratory tests, and medical supplies. 42 U.S.C. §§1395k, 1395r and 1395x(s). 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. §§1395j, 1395r, 1395s, §§1395t(a) and 1395t(g), and 1395w. See generally, Schweiker v. McClure, 456 U.S. 188, 189-190 (1982).

To make the administration of the Part B program more efficient, Congress authorized the Secretary of DHHS to contract with entities known as "carriers" to perform designated functions. 42 U.S.C. §§1395u, 1395u(f); 41 C.F.R. §421.200. Carriers perform a variety of functions as agents or contractors of the Secretary, such as determining the rates and amounts of payment for covered services, and processing and paying claims. 42 U.S.C. §1395u. Blue Cross/ Blue Shield (BC/BS) was the Medicare carrier for DHHS at all times relevant to this action.

## JURISDICTIONAL AND PROCEDURAL BACKGROUND

The Deputy I.G. for Civil Fraud notified the Respondent, a physician practicing medicine from two locations in New York City from 1976 to 1984, by letter dated February 8, 1985, of the I.G.'s intent to impose civil money penalties and assessments against him in the amount of $150,000 and to suspend him from participation in the Title XVIII (Medicare) and Title XIX (Medicaid) programs for a period of ten years. The I.G.'s notice of intent was based on a determination that between period February 1, 1980 and April 11, 1983, the Respondent had presented or caused to be presented 100 false or improperly filed claims for Medicare payment for 180 services that were not provided as claimed, in violation of the Act and Regulations. 6/ 7/ 8/ Of the 100 claims in issue here, 53 were received prior to August 13, 1981, the effective date of the Act (i.e., from February 10, 1980 through August 12, 1981) and 47 claims were received on or after the effective date of the Act, (i.e., from August 13, 1981, to April 11, 1983). In response, by

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6/ Section 1320a-7a(a)(1) of the Act and §101.102 of the Regulations define a false or improperly filed claim to be a claim for an item or service which the person knows or has reason to know was not provided as claimed.

7/ Section 1320a-7a(h)(2) of the Act and §101.101 of the Regulations define a "claim" as an application for payment submitted for an item or service for which payment may be made under the Title XVIII (Medicare), Title XIX (Medicaid) or Title V (Maternal and Child Health Services Block Grant) programs.

8/ Section 1320a-7a(h)(3) of the Act and §101.101 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.

letter dated March 7, 1985, the Respondent, through counsel, requested a hearing before an ALJ pursuant to section 101.109(b)(2) of the Regulations.

A prehearing conference was held in Washington, D.C., on June 18, 1985, at which time prehearing procedures, opportunities for discovery, and due process rights under the Regulations and Act were discussed and a schedule was set forth regarding discovery, exchanges of documents, motions and preparation for the hearing. At the prehearing conference, the I.G. agreed that for the 53 claims presented by the Respondent prior to the effective date of the Act (i.e., August 13, 1981), the maximum penalty can only be $2,000 for each false claim presented and not for each false item or service presented.

As a result of a request by the Respondent, no objection by the I.G., and for reasons of judicial economy, the June 14, 1985 Order and Summary of Prehearing Proceedings stated that this case was consolidated with an additional case involving the Respondent (identified as Docket No. C-12) for purposes of hearing both cases during the same week; the Order also stated that the hearing would be bifurcated and that two separate decisions would be issued. 9/ Accordingly, in view of the differing factual and procedural considerations, the hearing was conducted in two distinct parts; the first part involved Docket No. C-12, the §1128(a) suspension, and the second part involved this case, the civil money penalties, assessments, and section 1128(c) suspension. However, evidence entered into each record may be used in either case.

The Respondent moved for an indefinite adjournment, or continuance, of the hearing in this case and in Docket No. C-12 (prior to the hearing and again at the hearing) on the grounds that the Respondent would seek (on the basis of new evidence) to overturn the conviction upon which the I.G. based his mandatory suspension in Docket No. C-12 and which the I.G. cites as an aggravating circumstance in support of the I.G.'s proposed penalties, assessments and suspension in this case. The I.G. objected to the motion. I denied the Respondent's motion on August 19, 1985 verbally and issued a confirmation of said verbal order on August 20, 1985. I denied the motion a second time, at the hearing, on September 11, 1985. My reasons for denying the Respondent's motion were: First, this case would

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9/ Docket No. C-12 involves a November 25, 1983 Notice of Suspension sent to the Respondent which stated that the I.G. had determined that the Respondent had been convicted of a criminal offense related to his participation in the New York State Medicaid Program and, accordingly, he was, from December 10, 1983, mandatorily suspended from participation in the Medicare and Medicaid programs for a period of 10 years pursuant to §1128(a) of the Social Security Act, 42 U.S.C. §1320a-7(a) and its implementing regulations, 42 C.F.R. §420,000 et. seq. The Respondent's timely request for a hearing resulted in Docket No. C-12.

be reopened and Docket No. C-12 would be overturned if the Respondent was successful in overturning his guilty plea in State Court because the I.G. is required to "reinstate a party whose conviction has been reversed or vacated" Regulations §420.136(a). Next, the requested period of continuance and likelihood of success was too indefinite. Finally, the Respondent had not yet even begun to attempt to overturn his conviction in State Court (TR II/10 to 20). See, Michienzi v. Harris, 634 F 2d 345 (6th Cir. 1980).

A formal hearing was held in this case in New York City from September 10, 1985 through September 13, 1985, at which time the parties were afforded a full opportunity to present and have relevant evidence entered into the record, to present and cross-examine witnesses, and to present statements, motions and argument, as provided by the Act and Regulations. The parties were represented by counsel at the hearing and were given the opportunity to submit post-hearing written briefs and proposed findings of facts and conclusions of law. Seven witnesses testified on behalf of the I.G. and no witnesses testified on behalf of the Respondent. The I.G. presented a post-hearing brief, proposed findings of fact and conclusions of law and a reply brief. The Respondent submitted only a post-hearing brief. 10/

## ISSUES

The principal issues are:

1) Whether the I.G. proved by clear and convincing evidence that the Respondent knowingly presented or caused to be presented claims for Medicare payment, for services that were not provided as claimed, from February 10, 1980 to August 12, 1981, in violation of the Act and Regulations.

2) Whether the I.G. proved by a preponderance of the evidence that the Respondent knowingly presented or caused to be presented claims for Medicare payment, for services that were not provided as claimed, from August 13, 1981 to April 11, 1983.

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

4) Whether the amount of the proposed penalties, assessments, and suspension is reasonable and appropriate under the circumstances of this case, within the intent and meaning of the Act and Regulations.

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10/ "RB" references are to the Respondent's brief. "I.G.B" references are to the I.G.'s brief and "I.G.RB" references are to the I.G.'s reply brief.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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 Conclusions of Law: 11/ 12/ 13/

1. For the purposes of these proceedings, I have taken judicial notice of the statutes of the United States, the Regulations of the Secretary of DHHS, all other pertinent Regulations of the United States, the statutes of the State of New York, the Regulations of the New York State Department of Social Services, and all other pertinent Regulations of the State of New York as they existed at the time of the cause of action. Stip. 1, 2; TR II/5. 14/15/

2. The Secretary delegated to the I.G. the authority to take action under sections 1128A and 1128(c) of the Act pursuant to delegations of authority dated April 18, 1983, July 27, 1983, April 18, 1983, September 15, 1983, and September 26, 1983; see also, delegation of April 18, 1983 (48 Fed. Reg. 21662) (May 13, 1983) and May 6, 1983. Stip. 3 to 8; TR II/5, 6.

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11/ References to the transcript, the stipulations, Hearing Exhibits, and to the Findings of Fact and Conclusion of Law are as follows:

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| Transcript | = | TR (volume/page number) |
| Stipulations | = | Stip. (number) |
| I.G. Exhibit | = | I.G. Ex/(page number) |
| Respondent's Exhibit | = | R Ex/(page number) |
| ALJ Findings of Fact and Conclusions of Law | = | FFCL/(number) |

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

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

14/ The Findings of Fact numbered 1 to 13 were stipulated to by the parties and, accordingly, I have adopted them as my Findings of Fact.

15/ Stipulation references refer to the I.G.'s proposed stipulations of 7/19/85; which were all adopted by the Respondent, through counsel, at the hearing on September 11, 1985. TR II/5 to 9.

3. The DHHS has been authorized by the Department of Justice to proceed with this administrative action. Stip. 10; TR II/6.

4. The New York State Department of Social Services is the State Medicare Agency for the State of New York. Stip. B.1; TR II/7.

5. Blue Cross and Blue Shield (BC/BS) of Greater New York State was the fiscal agent (carrier) for the Medicare program in New York during all times relevant to this action. Stip. B.2; TR II/7.

6. Dr. Narendra Khurana is the Respondent in this case and was a provider-participant in the New York State Medicare program during the period of time relevant to this action. Stip. B.3; TR II/7.

7. BC/BS of Greater New York provided participants with and utilized procedure codes found in the "Blue Cross and Blue Shield Medicare Part B Prevailing Charges For All Covered Services" manual for submitting claims for physician services during the time period relative to this action. Stip. B.4; TR II/7; I.G. Ex 98.

8. The health insurance claim forms in evidence in this case are authentic and genuine copies of claim forms which the Respondent submitted, or caused to be submitted for payment under the Medicaid Program. Stip. B.5; TR II/7; I.G. Ex 12 to 81, 99 to 112, 125 to 149.

9. On February 8, 1985, the Inspector General (I.G.) notified the Respondent that the I.G. was proposing penalties, assessments and a suspension based on the I.G.'s determination that from February 10, 1980 through April 11, 1983, Respondent had submitted or caused to be submitted one hundred (100) claims for Medicare reimbursement for at least 180 services which the Respondent knew or should have known were not provided as claimed. I.G. Ex 9.

10. The parties stipulated that the chart attached to the I.G.'s February 8, 1985, Notice of Proposed Determination in this action is a true and accurate summary of the claim number, date of service, the procedure claimed, and the amount paid to the Respondent on each of the claims in evidence in this case. Actually, the chart shows the date the claim was received by the carriers, which is apparently what the parties meant by "date of service." Stip. B.6; TR II/7, 8; I.G. Ex 9.

11. The parties stipulated that the Respondent received payment from BC/BS as specified in the I.G.'s February 8, 1985 letter, as reimbursement for the one hundred (100) claims which he submitted or caused to be submitted and which are in issue in this case. Stip. B.7; TR II/8.

12. On February 24, 1983, the Respondent pled guilty in the Supreme Court of New York, County of New York, to One Count Grand Larceny in the Third Degree and one count of Offering a False Instrument for Filing in the First Degree. This plea was in satisfaction of an indictment charging him with 82 counts of Offering a False Instrument for Filing in First Degree and One Count of Grand Larceny in the Third Degree. I.G. Ex 1. The indictment was based upon evidence that the Respondent filed various Medical Assistance Practioner Claim Forms for reimbursement through the New York State Medicaid program in which he claimed that services had been provided to patients when, as he knew, the services had not been provided as claimed. Stip. B.8; TR II/9; I.G. Ex 2, 3.

13. On February 27, 1983, the Respondent was fined $5,000 for each count on which he was convicted, for a total of $10,000, and ordered to pay restitution of $55,000 plus $10,000 interest fora total of $65,000. Stip. B.9; TR II/9.

14. As the carrier for Medicare, BC/BS receives, reviews and processes claims (and reviews procedure codes listed) for care rendered to Medicare beneficiaries by providers of services. TR II/33-36.

15. To ensure compliance with its procedures, BC/BS routinely issues educational bulletins to participating physicians. These bulletins, entitled "Fast Facts," include information on Medicare law as well as procedure codes. TR II/46.

16. As a provider participant in the Medicare program, Respondent would have received these monthly bulletins. TR II/46.

17. Procedure code 1060 is defined as an injection of medication into a joint, ligament, tendon or tendon sheath. Single or multiple injection into one structure or site excluding interphalangeal, metacarpophalangeal or metatarsophalangeal joints. I.G. Ex 98/3.

18. Procedure code 9021 is defined as an office visit. I.G. Ex 98/2.

19. Procedure code 9024 is defined as a reevaluation exam. I.G. Ex 98/2, TR II/61.

20. Procedure code 9023 is defined as an extended office visit. An extended visit requires that the patient have a one-to-one relationship with the physician for a period of 30 minutes or more. TR II/45; I.G. Ex 98/2.

21. Each claim submitted to Medicare is supposed to contain the name of the patient, patient health insurance claim number, sex, mailing address, signature of the beneficiary, date signed, date of service, place of service, description of the procedure provided, diagnosis, charge for each of the services, name and address of the provider and the provider's code number. TR II/36.

22. The provider is also required to sign the claim, certifying that all the information on the billing form is true, accurate and complete. The certification reads "A physician's signature certified that a physician's services were personally rendered by the physician or under the physician's personal direction." TR II/38; I.G. Ex 147.

23. For each of the Medicare claims subject to this action, the Respondent certified as indicated in FFCL/21, 22. Stip. B. 6.

24. BC/BS received telephone calls from patients complaining that the Respondent was submitting claims to Medicare for services that the patients did not receive. TR II/51, 54, 55.

25. The patients that testified complained that the Respondent had them sign extra blank claim forms when they entered his office. TR II/90, 159, 160, 162; TR III/8.

26. The patients that testified received remittance statements for days they did not see the Respondent. TR II/94, TR III/120; I.G. Ex 87.

27. The Inspector General proved by clear and convincing evidence that the Respondent submitted or caused to be submitted twenty-two (22) claims for reimbursement in which the Respondent represented that he provided services to Catherine Arrington knowing that one or more of the services on each claim were not provided as claimed.

    a. The Respondent's claim (I.G. Ex 125) that he gave Ms. Arrington a shoulder injection on January 8, 1979 was false because he never gave her an injection in her shoulder. TR II/93, 97, 99, 102, 103, 104; I.G. Ex 125; I.G. Ex 9/5.

    b. The Respondent's claim (I.G. Ex 126) that he gave Ms. Arrington a shoulder injection on January 10, 1979 was false because he never gave her an injection in her shoulder. TR II/93, 97, 99, 102, 103, 104; I.G. Ex 126; I.G. Ex 9/5.

c. The Respondent's claim (I.G. Ex 128) that he gave Ms. Arrington two shoulder injections on January 16, 1979 was false because he never gave her an injection in her shoulder and never gave her more than one injection the same day. TR II/93, 97, 102, 103, 104; I.G. Ex 128, I.G. Ex 9/5.

d. The Respondent's claim (I.G. Ex 129) that he gave Ms. Arrington an electrocardiogram, or EKG, on January 16, 1979 is false because he never gave her an EKG. TR II/90, 97, 104, 121; I.G. Ex 129; I.G. Ex 9/5.

e. The Respondent's claim (I.G. Ex 130) that he gave Ms. Arrington a shoulder injection in addition to another injection on January 24, 1979 is false because he never gave her an injection in her shoulder and never gave her more than one injection the same day. TR II/93, 97, 99, 102, 103, 104; I.G. Ex 130, I.G. Ex 9/5.

f. The Respondent's claim (I.G. Ex 133) that he gave Ms. Arrington two injections on January 31, 1979 is false because he never gave her more than one injection the same day. TR II/103; I.G. Ex 133; I.G. Ex 9/5.

g. The Respondent's claims (I.G. Ex 134, 135) that he gave Ms. Arrington an extended office visit and a shoulder injection on February 22, 1979 are false because he never saw her in his office after January 1979, never saw her more than six times, never saw her for as long as 30 minutes, and never gave her an injection in her shoulder. TR II/89, 91, 92, 93, 97, 99, 101, 102, 103, 104, 120; I.G. Ex 134, 135; I.G. Ex 9/5.

h. The Respondent's claim (I.G. Ex 136) that he gave Ms. Arrington a shoulder injection on March 1, 1979 is false because he never saw her in his office after January 1979, never saw her more than six times, and never gave her an injection in her shoulder. TR II/89, 91, 93, 97, 99, 102, 103, 104, 120; I.G. Ex 136; I.G. Ex 9/6.

i. The Respondent's claims (I.G. Ex 137, 138) that he gave Ms. Arrington an office visit and two injections of March 5, 1979 are false because he never saw her in his office after January 1979, never saw her more than six times, and never gave her more than one injection the same day. TR II/89, 91, 97, 103, 104, 120; I.G. Ex 137, 109, 138; I.G. Ex 9/6.

j. The Respondent's claim (I.G. Ex 139) that he gave Ms. Arrington an office visit and injections in both shoulders on March 21, 1979 are false because he never saw her in his office after January 1979, never saw her more than six

times, and never gave her a shoulder injection or more than one injection the same day. TR II/89, 91, 93, 97, 99, 102, 103, 104, 120; I.G. Ex 139, 107; I.G. Ex 9/6.

k. The Respondent's claims (I.G. Ex 140, 141) that he gave Ms. Arrington an office visit and injections in both shoulders on March 22, 1979 are false because he never saw her in his office after January 1979, never saw her more than six times, and never gave her a shoulder injection or more than one injection the same day. TR II/89, 91, 93, 97, 99, 102, 103, 104, 120; I.G. Ex 140, 141; I.G. Ex 9/6.

l. The Respondent's claims (I.G. Ex 142, 143) that he gave Ms. Arrington an office visit and two injections on March 30, 1979 are false because he never saw her in his office after January 1979, never saw her more than six times, and never gave her more than one injection the same day. TR II/89, 91, 97, 103, 104, 120; I.G. Ex 142, 110, 143, 112; I.G. Ex 9/6.

m. The Respondent's claims (I.G. Ex 144, 145) that he gave Ms. Arrington an extended office visit and a shoulder injection on April 12, 1979 are false because he never saw her in his office after January 1979, never saw her more than six times, never saw her for as long as 30 minutes, and never gave her a shoulder injection. TR II/89, 91, 92, 93, 97, 99, 101, 102, 103, 104, 120; I.G. Ex 144, 108, 145; I.G. Ex 9/6.

n. The Respondent's claims (I.G. Ex 148, 149) that he gave Ms. Arrington an office visit and injections in both shoulders on April 27, 1979 are false because he never saw her in his office after January 1979, never saw her more than six times, and never gave her a shoulder injection or more than one injection the same day. TR II/89, 91, 93, 97, 99, 102, 103, 104, 120; I.G. Ex 146, 147, 111; I.G. Ex 9/7.

o. The Respondent's claims (I.G. Ex 148, 149) that he gave Ms. Arrington an office visit and shoulder and vitamin injections on May 31, 1979 are false because he never saw her in his office after January 1979, never saw her more than six times, never gave her a shoulder or vitamin injection or more than one injection the same day. TR II/89, 91, 93, 97, 99, 102, 103, 104, 120; I.G. Ex 148, 149; I.G. Ex 9/7.

28. The Inspector General proved by clear and convincing evidence that the Respondent was paid a total of $673.78 on the twenty-two (22) false claims listed in Finding No. 27 a - o (Catherine Arrington). I.G. Ex 9/5-7; Stip. 6, 7; TR II/7-8.

29. The Inspector General did not prove by clear and convincing evidence that the Respondent was paid (a) $61.28 for a shoulder injection allegedly given to Ms. Arrington on February 22, 1979 (I.G. Ex 135); (b) $45.96 for a shoulder injection allegedly given to Ms. Arrington on March 1, 1979 (I.G. Ex 136); and (c) $45.96 for a shoulder injection allegedly given to Ms. Arrington on April 12, 1979 (I.G. Ex 145), even though these are false claims and the parties stipulated Respondent was paid these amounts. I.G. Ex 86/1; I.G. Ex 9/5-7; Stip 6, 7; TR II/7-8.

30. The Inspector General did not prove by clear and convincing evidence that Respondent falsely claimed (a) an office visit and knee injection allegedly given to Ms. Arrington on January 8, 1979 (I.G. Ex 125); (b) an office visit allegedly given to Ms. Arrington on January 10, 1979 (I.G. Ex 127); (c) an office visit allegedly given to Ms. Arrington on January 16, 1979 (I.G. Ex 129); (d) an office visit and an injection allegedly given to Ms. Arrington on January 24, 1979 (I.G. Ex 130); (e) an office visit and a knee injection allegedly given to Ms. Arrington on January 27, 1979 (I.G. Ex 131); and (f) an office visit and a knee injection allegedly given to Ms. Arrington on January 31, 1979 (I.G. Ex 132, 133). I.G. Ex 125, 127, 129, 130, 131, 132, 133; I.G. Ex 9/5.

31. The Inspector General proved by a preponderance of the evidence that the Respondent submitted or caused to be submitted nineteen (19) claims for reimbursement in which he represented that he provided 19 services to Katherine Clinkscales knowing that these 19 services were not provided as claimed. Respondent's claims that he gave Ms. Clinkscales injections on the following dates are false because he never gave her more than one injection the same day:

| | | |
|---|---|---|
| a. | November 17, 1980. | I.G. Ex 49. |
| b. | November 25, 1980. | I.G. Ex 50. |
| c. | December 1, 1980. | I.G. Ex 51. |
| d. | December 5, 1980. | I.G. Ex 52. |
| e. | December 12, 1980. | I.G. Ex 53. |
| f. | December 29, 1980. | I.G. Ex 54. |
| g. | January 3, 1981. | I.G. Ex 55. |
| h. | January 9, 1981. | I.G. Ex 55. |
| i. | January 21, 1981. | I.G. Ex 56. |
| j. | February 16, 1981. | I.G. Ex 62C. 106. |
| k. | August 25, 1981. | I.G. Ex 62D. |
| l. | September 17, 1981. | I.G. Ex 62B. |
| m. | October 5, 1981. | I.G. Ex 62A. |
| n. | October 9, 1981. | I.G. Ex 57. |
| o. | October 21, 1981. | I.G. Ex 58. |

p. October 29, 1981. I.G. Ex 59.
q. August 17, 1982. I.G. Ex 60.
r. September 2, 1982. I.G. Ex 61.
s. January 25, 1983. I.G. Ex 62.

TR II/12

32. The Inspector General proved by a preponderance of the evidence that the Respondent claimed a total of $1502.00 in reimbursement for the nineteen (19) services allegedly given to Ms. Clinkscales as indicated in Finding No. 31 a - s. I.G. Ex 49 - 62D.

33. The Inspector General did not prove by a preponderance of the evidence that one of two injections which Respondent allegedly gave Ms. Clinkscales on December 12, 1980, and one of two injections which Respondent allegedly gave Ms. Clinkscales on December 29, 1980, were falsely claimed. I.G. Ex 53, 54; I.G. Ex 9/7.

34. The Inspector General did not prove by a preponderance of the evidence that a single injection which Respondent allegedly gave Ms. Clinkscales on May 5, 1981 was falsely claimed. I.G. Ex 9/8; I.G. Ex 115/6.

35. The Inspector General proved by clear and convincing evidence that the Respondent submitted or caused to be submitted twelve (12) claims for reimbursement in which he represented that he provided services to Fannie Mae Jackson knowing that one or more of the services listed on each claim were not provided as claimed.

a. Respondent's claim that he gave Ms. Jackson two injections on July 13, 1979 was false because he never gave her more than one injection the same day. TR II/147, 150; I.G. Ex 12; I.G. Ex 9/11.

b. Respondent's claims that he gave Ms. Jackson extended office visits on July 18, 20, and 23, 1979 were false because he never saw her for as long as 30 minutues. TR II/145; I.G. Ex 14, 16, 18; I.G. Ex 9/11.

c. Respondent's claims that he gave Ms. Jackson a second injection on August 3, 1979 and two injections on August 7, 1979 were false because he never gave her more than one injection the same day. TR II/147, 150; I.G. Ex 19, 20; I.G. Ex 9/11.

d. Respondent's claims that he gave Ms. Jackson extended office visits on August 10 and 20, 1979 were false because

he never saw her for as long as 30 minutes. TR II/145; I.G. Ex 22, 27; I.G. Ex 9/12.

e. Respondent's claims that he gave Ms. Jackson extended office visits and two injections on each of August 14 and 16, 1979 were false because he never saw her for as long as 30 minutes and never gave her more than on injection the same day. TR II/145, 147, 150; I.G. Ex 23, 24, 25, 26; I.G. Ex 9/12.

36. The Inspector General proved by clear and convincing evidence that the Respondent was paid a total of $290.50 on the twelve (12) false claims listed in Finding No. 35 a - d. I.G. Ex 9/11, 12; I.G. Ex 82.

37. The Inspector General did not prove by clear and convincing evidence that Respondent was paid $66.40 for an extended office visit allegedly given to Ms. Jackson on July 18, 1979, even though this was a false claim and the parties stipulated that the Respondent was paid this amount. I.G. Ex 14; I.G. Ex 82/1, I.G. Ex 9/11.

38. The Inspector General did not prove by clear and convincing evidence that Respondent falsely claimed a service (procedure coded as "7238" but illegible on the claim form and not otherwise identified in the record) allegedly given to Ms. Jackson on July 17, 1979; a knee injection allegedly given to Ms. Jackson on each of July 18, 1979; July 20, 1979; July 23, 1979; August 7, 1979; and August 10, 1979; a shoulder injection allegedly given to Ms. Jackson on August 14, 1979; a knee injection and an electrocardiogram (EKG) allegedly given to Ms. Jackson on August 16, 1979; an EKG and a shoulder injection allegedly given to Ms. Jackson on August 20, 1979; an office visit allegedly given to Ms. Jackson on August 21, 1979. I.G. Ex 14, 15, 17, 21, 24, 25, 26, 27, 28, 29; I.G. Ex 9/11, 12.

39. The Inspector General provided by clear and convincing evidence that the Respondent presented or caused to be presented nine (9) claims for reimbursement in which he represented that he provided services to Enrique Martinez knowing that one or more of the services listed on each claim were not provided as claimed.

a. Respondent's claims that he gave Mr. Martinez two injections on each of July 25, 1979 and September 1, 1979 were false because he never gave him more than one injection the same day. TR II/166; I.G. Ex 30, 32; I.G. Ex 9/9.

b. Respondent's claims that he gave Mr. Martinez two knee injections on each of August 27, 1979; September 21, 1979; September 25, 1979; October 4, 1979; and October 8, 1979 were false because he never gave him a knee injection and never gave him more than one injection the same day. TR II/158, 160, 164, 165, 166, 170, 179; I.G. Ex 31, 33, 34, 35, 36; I.G. Ex 9/9.

c. Respondent's claim that he gave Mr. Martinez an ankle injection in addition to another injection on October 15, 1980 is false because he never gave him an ankle injection and never gave him more than one injection the same day. TR II/158, 160, 164, 165, 166, 170, 179; I.G. Ex 45; I.G. Ex 9/10.

d. Respondent's claim that he gave Mr. Martinez a re-evaluation examination on June 13, 1981 was false because he never saw Mr. Martinez in the office after November 1980. TR II/163, 165; I.G. Ex 47; I.G. Ex 9/10.

40. The Inspector General provided by clear and convincing evidence that the Respondent was paid a total of $309.26 on the nine (9) false claims listed in Finding 39 a - d.

41. The Inspector General did not prove by clear and convincing evidence that Respondent was paid $99.60 for an injection allegedly given to Mr. Martinez on July 25, 1979, and $78.16 for an injection allegedly given to Mr. Martinez on September 1, 1979, even though these were both false and the parties stipulated that the Respondent was paid these amounts. I.G. Ex 114/1; I.G. Ex 30, 32; I.G. Ex 9/9.

42. The Inspector General proved by a preponderance of the evidence that the Respondent submitted or caused to be submitted seven (7) claims for reimbursement in which he represented that he provided 9 services to Enrique Martinez knowing that these 9 services were not provided as claimed.

a. Respondent's claim that he gave Mr. Martinez a knee injection on October 12, 1979 was false because he never gave him a knee injection. TR II/158, 160, 164, 165, 170; I.G. Ex 37; I.G. Ex 9/10.

b. Respondent's claims that he gave Mr. Martinez an injection in addition to another injection on each of April 30, 1980; June 3, 1980; August 6, 1980; August 11, 1980; August 13, 1980; August 22, 1980 and June 15, 1981 were false because he never gave him more than one injection the same day. TR II/166; I.G. Ex 39, 41, 42, 43, 48; I.G. Ex 9/10, 11. See also, Finding No. 42. f.

c. Respondent's claims that he gave Mr. Martinez a elbow injections on each of August 6, 1980 and August 22, 1980 were false because he never gave him an elbow injection. TR II/158, 160, 164, 165, 170; I.G. Ex 42, 43; I.G. Ex 9/10.

d. Respondent's claim that the gave Mr. Martinez an ankle injection in addition to another injection on October 15, 1980 was false because he never gave him an ankle injection and never gave him more than one injection the same day. TR II/158, 160, 164, 165, 166, 170; I.G. Ex 45; I.G. Ex 9/10.

e. Respondent's claim that he gave Mr. Martinez an extended office visit on December 1, 1980 was false because he never saw him for as long as 30 minutes and never saw him in the office after November 28, 1980. TR II/157, 163, 164, 165; I.G. Ex 46; I.G. Ex 9/10.

f. Respondent's claim that he gave Mr. Martinez an injection on June 15, 1981 was false because he never saw him in the office after November 28, 1980. TR II/163, 165; I.G. Ex 48; I.G. Ex 9/11. See also, Finding No. 42. b.

43. The Inspector General proved by a preponderance of the evidence that the Respondent claimed a total of $727 in reimbursement for the nine services allegedly given to Mr. Martinez as indicated in Finding No. 42. a - f.

44. The Inspector General did not prove by a preponderance of the evidence that a shoulder injection which Respondent allegedly gave to Mr. Martinez on (a) March 20, 1980, (b) May 6, 1980, or (c) October 2, 1980, were falsely claimed. I.G. Ex 38, 40, 44; I.G. Ex 9/10

45. The Inspector General did not prove by clear and convincing evidence that a "PPB" (procedure code 9399) and an office visit which Respondent allegedly gave Eva Pearson on January 10, 1981 were falsely claimed. I.G Ex 95, 96; I.G. Ex 65; I.G. Ex 9/13.

46. The Inspector General did not prove by a preponderance of the evidence that the services listed in I.G. Ex 9/13-15 which Respondent allegedly gave Eva Pearson on January 3 and 24, 1981; February 9, 1981; and March 2, 5, 12 and 14, 1981 were falsely claimed. I.G. Ex 95, 96; I.G. Ex 63, 64, 66-81; I.G. Ex 85/3, 5.

47. The Inspector General proved by clear and convincing evidence that Respondent knew that the forty-three (43) claims which the Respondent presented or caused to be presented (and received by the carrier) prior to August 13, 1981 each contained alleged services which were not provided as claimed, and by filing these claims the Respondent intended to defraud the Medicare program.

48. The Inspector General proved by a preponderance of the evidence that Respondent knew that twenty-eight (28) services listed on false claims which the Respondent presented (and which were received by the carrier) after August 13, 1981 were not provided as claimed.

49. The Respondent has responsibility under the Act and Regulations to be informed of the statutory, regulatory, and program requirements and has an obligation to ensure that services for which he claimed reimbursement were in fact provided as claimed.

50. Each of the forty-three (43) claims and twenty-eight (28) services referred to above are subject to a determination under Section 101.102 of the Regulations.

51. The Inspector General proved by clear and convincing evidence the following aggravating factors:

    a. The false claims were submitted over a lengthy period of time, were many in number, involved substantial amounts, and were part of a pattern of actions by the Respondent to systematically defraud the federal and state programs of medical assistance to the elderly and poor which went far beyond this case.

    b. The Respondent attempted to obstruct my efforts to conduct a full hearing and arrive at the truth by his delay in searching for records sought by the Inspector General and by his selective production of those records (deemed most favorable to his case) (several days after he allegedly found them), without advising the Inspector General that the records had been found, prior to the Respondent's attempt to use them in cross examination.

52. The Respondent proved by a preponderance of the evidence (based on evidence introduced by the I.G.) the following mitigating factors:

    a. Prior to and during the period in question the physical condition of the Respondent's infant daughter and the connected nervous collapse of his wife placed him under great mental strain; he was also dependent on drugs.

b. The Respondent mental state and dependency on drugs affected his work and may have affected his judgment on legal, ethical, and moral questions concerning his false claims for reimbursement from the Medicare program.

53. The same factors that are considered in determining penalties and assessments are to be considered in determining the length of a suspension. 45 C.F.R. §101.107.

54. The maximum penalty in this case is $142,000 ($2000 x 71) (43 pre-August 13, 1981 claims containing one or more services not provided as claimed, plus 28 post-August 13, 1981 services not provided as claimed). The Inspector General sought to prove that 53 pre-August 13, 1981 claims plus 98 post-August 13, 1981 services were false, which would have made the maximum penalty $303,000. The Inspector General proposed a penalty of $138,800, which is the equivalent of $771.11 for each allegedly false claim or service. At the $771.11 penalty rate, the total penalty for the 43 claims and 28 services would be, and is, $54,748.81.

55. The maximum assessment in this case is $7,005.08 (43 claims containing one or more services not provided as claimed for which Respondent was paid $1,273.54, plus 28 post-August 13, 1981 services not provided as claimed, for which Respondent claimed $2,229; a total of $3,502.54, doubled). The Inspector General proposed an assessment of $11,200 out of a total maximum assessment of $33,145.50 (if the Inspector General had proved false the 53 claims plus 98 other services alleged to be false), which is equivalent to double the amount of $.33 for each $1.00 paid or claimed. At the .33 rate, the total assessment for double the amount paid on the 43 claims and double the amount claimed on the 28 services would be, and is, $2,311.67.

56. The $33,157.73 penalty and $840.53 assessment imposed for those claims received by Blue Cross-Blue Shield prior to August 13, 1981, are not greater than the amounts which could have been imposed under the False Claims Act.

57. Any part of the following Discussion and any part of this Decision and Order preceding the Findings of Fact and Conclusions of Law which is an obvious finding of fact or a conclusion of law is hereby incorporated herein as a finding of fact or conclusion of law.

## DISCUSSION

### I. The Application of the Act and Regulations to this Case

A discussion of how the Act and the regulations apply to the general facts in this case is outlined earlier in this Decision and Order. That discussion, i.e., "the Law and Regulations," is incorporated herein by reference and will not be repeated here.

### II. The Hearing

The Regulations require that a full and fair trial-type hearing before an ALJ be conducted; that was done in this case. See, Regulations §101.111 (right to a hearing), 101.113 (notice of hearing), 101.114 (burden of proof), 101.115 (right to a fair hearing to be conducted by an ALJ), 101.116 (rights of parties), 101.117 (discovery rights), 101.118 (evidence and witnesses), 101.120 (no ex parte contacts) 101.121 (separation of functions), 101.122 (official transcript), 101.123 (briefs and proposed findings of fact and conclusions of law) 101.124 (record), 101.125 (decisions and order), 101.126 (judicial review), and 101.132 (limitations); Londoner v. Denver, 210 U.S. 373, 386 (1908); DAVIS, Administrative Law Treatise, 2d Ed. 1978, chapters 12, 13. The Respondent had notice of the I.G.'s proposals, a fair hearing, the opportunity for discovery and the opportunity to cross-examine witnesses. See, Mathews v. Eldridge, supra, at p. 335 (1976); Greene v. McElroy, 360 U.S. 474 (1959). Moreover, under the Regulations, the parties had the right to cross-examine all witnesses called by the opposing party well beyond the normal scope of cross-examination because §101.118(d) provides:

> (d) a witness may be cross-examined on any matter relevant to the proceeding without regard to the scope of his or her direct examination.

### III. The Use of Hearsay in this Case

Although hearsay is admissible in this proceeding, it must be credible and reliable and used in a fair manner to have any probative value. See, 5 U.S.C. §556(d); Catholic Medical Center v. NLRB 1589 F. 2d 1166 (2d Cir. 1978); DAVIS, supra at §§16.4, 16.5, 16.6, 16.7, and 16.8. Generally, with regard to the admission of prior sworn statements of patients in lieu of testimony, the dispositive case on this issue is Richardson v. Perales, 402 U.S. 389 (1971) which holds that where the Respondent fails to attempt to confront a witness, the witness statement may be, in most cases, substantial evidence, even though it is hearsay. (This issue will be discussed in more detail infra, i.e., regarding the evidence of specific claims in issue submitted with regard to Eva Pearson.)

IV. Adverse Inferences

In this case, seven witnesses testified on behalf of the I.G. and no witnesses testified on behalf of the Respondent. The Respondent did not testify on behalf of himself; he was, however, called by this ALJ and voluntarily appeared for the limited purpose of testifying as to his efforts to comply with my discovery Order requiring him to produce certain patient logs. See, TR IV/5 to 65. 16/

In an attempt to bring additional relevant evidence before me, the I.G. requested that the Respondent produce a handwriting sample, his disability history and his patient logs for the period of time in issue. A review of the transcript and the record makes it clear (TR. III/23-32) that the I.G. made repeated requests for this information as early as June 1985. TR III/31. The Respondent made the decision not to produce a handwriting sample and information concerning his disability claim. TR III/61, 62. After hearing the Respondent testify, and observing the Respondent as he testified, I find that he withheld production of his patient logs until they could not be used against him by the I.G.. I am not certain whether the Respondent did this by design or because of his reduced mental capacity. See, "The Respondent's Knowledge And His Intent to File False Claims," infra. The I.G. alleges that the logs would show that the Respondent billed for certain patient services on days that the said patient did not visit his office. I find that the logs probably would have corroborated the testimony of the patients of who so testified and the statements of Eva Pearson. I find this to be so because the Respondent found and produced only those pages of the logs that helped his case. The Respondent's failure to produce evidence within his control fairly warrants the inference that the evidence, if produced, would have been adverse. Daniel v. United States, 234 F. 2d 102 (5th Cir. 1956); Local 167 v. United States, 291 U.S. 293.

16/ It should be noted that the reasons the Supreme Court held that the Self-Incrimination Clause of the Fifth Amendment did not apply in United States v. Ward, 448 U.S. 242, 251 to 254 (1980) was because the federal statute in question in that case specifically provided that any information obtained "shall not be used against any such person in any criminal case." Here, there is no such protection. Thus, this privilege is applicable here if a person could show that the information requested or question asked at the hearing would prejudice them in respect to later or current criminal proceedings; it is not, however, a blanket privilege and must be determined on a question by question basis. There was no attempt made by the Respondent to testify on his own behalf; so this privilege, although mentioned by the Respondent's counsel, was never actually invoked by the Respondent and the Respondent did not attempt to defend this action by presenting himself or any other witnesses.

Several of the beneficiaries interviewed by Mr. Jerson, the I.G. investigator, stated that they did not recognize the patient signature on claims submitted by the Respondent on their behalf. TR II/103. The I.G. requested a sample of the Respondent's handwriting to determine whether he may have forged the beneficiary's name on the claim form. The Respondent's refusal to produce the requested handwriting sample raises the inference that had it been produced, analysis would reveal that the Respondent had forged the claims in questions. Thus, his failure to provide a handwriting sample tends to corroborate the testimony of those witnesses.

A review of the Respondent's testimony (TR IV/5 to 65) reveals that the Respondent was evasive and inconsistent in his response to questioning by the I.G. and to my questions. The Respondent could not recall events that had occurred two or three days prior to his testifying (TR 9/13 at 28-38), and could not or would not remember clearly what he found during the search of his office only days before. TR 9/13 at 28, 34. The Respondent testified that he only found one book during his search (TR 9/13 at 31), although his counsel referred to the production of books. TR IV/34, 60. Moreover, the patient appointment book the Respondent produced was indexed to correspond to rebuttal or cross-examination of the I.G.'s witnesses. The Respondent testified that he undertook to index the book without consulting with his attorney or even notifying him that the book had been "discovered". TR IV/61. Also, he admitted that he had altered the patient sign-in sheets he produced by writing dates on the sheets. TR IV/39. Although the Respondent initially suggested that the dates were already on the sheets when he found them (TR IV/37, 38), it became clear that he had marked the documents. TR III/48, 51.

I find that the Respondent's behavior in not searching for the requested documents at an earlier date and his selective production of only those documents that helped his case obstructed the hearing in this case, and that this is an aggravating factor. Also, the Respondent's behavior requires the inference that the items withheld would have made the Respondent's scheme to intentionally defraud Medicare even more apparent.

V. The Respondent's Knowledge And His Intent To File False Claims

A thorough review of the entire record illustrates that the Respondent had knowledge that the false claims he submitted to Medicare were indeed false. The most compelling proof is provided by the testimony of the patients at the hearing. Each of the Medicare beneficiaries that testified denied receiving services billed by The Respondent. These patients testified that the Respondent would have them sign extra claim forms when they went to see him (TR II/90, 159, III/8) and that they would later receive billing statements from Medicare for services by the Respondent that they

had not received. The Respondent had a well-established scheme which he used to defraud the Medicare program. When Medicare patients entered Dr. Khurana's medical offices, they were told that they had to sign a number of blank claim forms. I.G. 91, 92, 93, 96; TR II/90, 159, III/8. If the patients asked why it was necessary to sign these extra blank forms, they were told either that it was "necessary" (I.G. 92; TR II/90), or that the Respondent needed a copy (TR II/160, TR III/8). The Respondent would fill out these blank claim forms and list various services that the Respondent had not rendered and submit these forms to the Medicare program for reimbursement. The program paid these claims in due course and would send monthly billing statements to the patients identified as having received these services. Some of the patients opened and read their statements and called the carrier (BC/BS) to complain that the Respondent was billing for services that they had not received. TR II/54. On the basis of these complaints, the Respondent's scheme was revealed. TR II/55.

In addition to the evidence of billing fraud supplied by the testimony of patients at the hearing, the Respondent's wife, Dr. Rhoopa Khurana, provided further proof and corroboration of his scheme to cheat not only the Medicare but also the and Medicaid program as well. During the period of time that the Respondent was being investigated by the New York State Medicaid Fraud Unit, Dr. Rhoopa Khurana made a telephone call to a New York radio talk show on WABC hosted by Mrs. Judith Kurianski, 17/ a health professional who counsels individuals who call in to discuss their personal problems over the air. TR III/135 to 148. The Respondent's wife gave her name as "Mary" when she called the radio talk-show and

17/ At the hearing, the Respondent's wife appeared by counsel and opposed the I.G.'s motion for an order to enforce appearance as a witness against her husband. I ruled at the hearing that the Respondent's wife did not have to testify in this case or in Docket No. C-12 on the grounds that (1) the principles of the common law as interpreted by the courts of the United States govern the law of privilege because federal law supplied the rule of decision in this case (see, Rule 501 of the Federal Rules of Evidence), and (2) the case of Trammel v. United States, 445 U.S. 40 (1979), stands for the proposition that a wife cannot be compelled to testify against her husband in a federal forum (on the basis of the marital privilege). Here, however, the Respondent's wife waived the marital privilege with regard to the taped conversation with the radio talk-show host, which is in evidence in this case, because she volunteered information about her husband to thousands of people over the radio. TR I/80 to 85.

spoke to Ms. Kurianski. The radio station policy required callers to give a phone number in case they are disconnected. New York State investigators traced the number given by "Mary" to the home of Drs. Narendra and Rhoopa Khurana. Ms. Khurana's identity is further confirmed by the fact that, during the conversation, she gave a large amount of personal and family history which corresponded exactly to the personal history of Rhoopa and Narendra Khurana. Furthermore, counsel for the Respondent admits that the caller was Ms. Khurana. TR IV/84, 88; TR III/151.

At the request of the I.G and over the objection of the Respondent, this tape was played and transcribed into the record in this case (TR III/142 to 148) during the testimony of Mr. Barry Jerson, an investigator (program-analyst) for the I.G. TR III/114 to 174. While the Respondent's counsel originally objected to the admission of the tape into evidence, and objected to having the tape transcribed by the court reporter in this case, and having the transcription be used as evidence, the Respondent admits that the voice on the tape was that of the Respondent's wife and urges that I consider and weight the evidence to support the Respondent's argument that the I.G. failed to consider certain factors as mitigating factors. RB at p. 12.

The Respondent now argues that Ms. Khurana's statements about the guilt of her husband be discounted, but that her statements about the Respondent's medical and psychological strain be given great weight as mitigating factors. The I.G. argues that I should give great weight to the statements of the Respondent's guilt, but does not equally address the Respondent's arguments concerning the mitigating factors. The evidence offered by the I.G. is a double-edged sword; it addresses not only the Respondent's intent to cheat Medicaid, but outlines problems which impaired the Respondent's ability to work. I give equal weight to all of Ms. Khurana's statements. The evidence reveals shocking statements concerning the Respondent's intent to cheat Medicaid, drug-addition causing impairment of the Respondent, a nervous breakdown of the Respondent's wife, a daughter with cerebral palsy and her operation, unhappiness and depression. TR III/142 to 148. I find that the words of the Respondent's wife illustrate a clear concern of the well-being of herself, her family and her husband's problems. She is also a physician and I find her statements concerning her husband to be credible. I find that the problems Ms. Khurana cited are evidence of the Respondent's mental condition, (i.e., that the Respondent was under great mental strain, that the Respondent's daughter was suffering from cerebral palsy, that

the child's condition and his wife's nervous breakdown affected the Respondent, that the Respondent was suffering from dependency on drugs, and that the dependency and mental strain affected his ability to work). It should be noted that although he now admits that his wife's description of his mental state and drug dependency is correct, the Respondent was remiss in not coming forward. At the very least, the Respondent should have explained how his drug dependency and family problem lessened his moral culpability. Instead, the Respondent sat back, let the I.G. provide the evidence in the case that the Respondent later seized upon as evidence of mitigating factors, and then still took no affirmative action.

In her phone conversation, Rhoopa Khurana stated that she was a physician who was married to a physician who is very unscrupulous because her husband had been defrauding the Medicaid program for 10 years; she said that she had tried, but was unable, to change him from his criminal ways. TR III/143, 146. She said that she did not need to inform the authorities because Medicaid had already begun investigating her husband. TR III/ 145. The Respondent's wife discussed the scheme in which the Respondent was involved and revealed his intent to cheat.

In admitting his guilt to his State crime of cheating Medicaid, the Respondent specifically admitted that he had intended to defraud the Medicaid program by filing false claims. I.G. 3. There is also evidence that the Respondent intended to defraud the Medicare program as he had cheated the Medicaid program. When Catherine Arrington began receiving numerous carrier statements for Medicare services that she knew she had not received, she confronted the Respondent; The Respondent told her not to worry about the bills, and even billed her for an office visit on the day she went to complain, although no services had been rendered. TR II/94. When she continued to receive billing statements, Ms. Arrington again complained to the Respondent. The Respondent asked "why should she worry, it [the money] was not coming out of her pocket." TR II/95-122; I.G. 90. Ms. Jackson stated that Dr. Khurana told her not to worry about the extra claims he was submitting under her name since Medicare was paying. I.G. 87, I.G. 88. 18/

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18/ Even though I found Ms. Khurana's testimony to be credible and found that negative inferences should be drawn against the Respondent for his obstruction in this case, I still reviewed the remaining evidence in the record (i.e., primarily the testimony of the other witnesses in this case) on its own merits and found that it alone established the liability of the Respondent. In fact, if anything, Ms. Khurana's statements help the Respondent by establishing mitigating circumstances and do nothing more than corroborate the magnitude of his scheme to intentionally defraud the Medicare and Medicaid programs; if her testimony were to be stricken from the record, the result would be more harmful to the Respondent because evidence of mitigating factors would be absent.

VI. The I.G. Proved By Clear And Convincing Evidence That The Respondent Knowingly Presented Or Caused To Be Presented Forty-Three (43) Claims (of the 53 Claims In Issue) For Medicare Payment, For Services That Were Not Provided As Claimed (Where the Claims Were Received By The Carrier From February 10, 1980 to August 12, 1981) In Violation Of The Act And Regulations

The I.G. argues that he has shown by clear and convincing evidence (1) that the Respondent knowingly presented 53 Medicare false claims and received by the carrier, BC/BS, from February 10, 1980 to August 12, 1981, for services that were not provided as claimed, (2) that the Respondent was not entitled to any payment for the claims submitted, and (3) that the claims at issue were a small part of a continuing scheme by the Respondent to obtain Medicare and Medicaid reimbursement in violation of the Act and Regulations. The I.G. also argues that he also has proven (1) intent to defraud, (2) that the Respondent knowingly filed the claims in issue, (3) that there exist substantial aggravating factors, and (4) that the amount of penalties and assessments proposed are less than what could have been imposed under the False Claims Act.

In addition to the objections and motions made by the Respondent outlined above, the Respondent argues that (1) the evidence presented by the I.G. was insufficient to meet the burden of proof required, and (2) that there are mitigating circumstances present in this case that the I.G. failed to consider. The Respondent also argues that the witnesses presented by the I.G. were not credible because of their age and inability to remember dates, and accordingly, that their entire testimony is unworthy of belief and should be stricken.

The Act and Regulations require that, for claims received by the carrier prior to August 13, 1981, the I.G. prove by clear and convincing evidence that the Respondent presented or caused to be presented false claims that could have rendered the Respondent liable under the False Claims Act for payment of an amount not less than that proposed by the I.G. 45 C.F.R. §101.114(b). The civil False Claims Act provides for a civil penalty of $2,000 for each false claim and an amount equal to two times the amount of damages the Government sustains. The Act and Regulations as well as the False Claims Act are applicable to false claims submitted to the Medicaid and Medicare programs. See, United States v. Jacobson, 467 F. Supp. 507 (S.D. N.Y. 1979); U.S. ex rel. Davis v. Long's Drugs Inc. 411 F. Supp. 1144 (S.D. Cal. 1976). As one federal court noted, any fraudulent claim "results in an impairment of the federal treasury because the Government expends money it would not expend 'but for' the fraud." U.S. ex rel. Fahner v. Alaska, 591 F. Supp. 794, 798 (N.D. Ill. 1984).

The Second Circuit has interpreted the knowledge or intent to defraud requirements of the False Claims Act as requiring that

the Government demonstrate the tort of intentional fraud and misrepresentation. United States v. Repass 688 F. 2d 154 (2d Cir. 1980) quoting United States v. Ekelman and Associate, 532 F. 2d 545, (6th Cir. 1976). The Second Circuit follows the Sixth Circuit's standard in requiring that this intent be demonstrated by clear, unequivocal and convincing evidence. Ekelman, supra, at p. 548. I find that the I.G. has proven by clear and convincing evidence that the Respondent knowingly submitted forty-three (43) false Medicare claims in issue here (that were received by the carrier prior to August 13, 1981) and that the Respondent intended to defraud and cheat the Medicare program. See, Discussion, Section V, supra.

The following is a summary of each of the alleged false claims in issue here which were presented by the Respondent prior to August 13, 1981 and the reasons why they were or were not proven by clear and convincing evidence to be false claims under the Act and Regulations (using the False Claims Act standard): 18/

A. The I.G. Proved By Clear and Convincing Evidence That Twenty-Two (22) Claims (Of The 25 Claims In Issue) Listing Services Allegedly Rendered to Catherine Arrington are False Claims

The I.G. proved by clear and convincing evidence that the Respondent intended to defraud the Medicare program by filing false claims in violation of the Act and Regulations for the period in issue in this case. See, Discussion, "V The Respondent's Knowledge And His Intent to File False Claims," supra. The I.G. proved by clear and convincing evidence that the Respondent presented twenty-two claims, each containing one or more services allegedly rendered to Catherine Arrington but not provided as claimed, in violation of the Act and Regulations (using the False Claims Act standard). FFCL/27 a to o, 28. The I.G. did not prove by clear and convincing evidence (a) that three other claims in issue submitted by Respondent were false claims, and

18/ It should be generally noted that I found each of the four patient-witnesses to be credible and reliable and their testimony to be probative in spite of their advanced ages (Fannie May Jackson, age 94; Ms. Katherine Clinkscales, age 74; Catherine Arrington age 73; and Enrique Martinez, age 78). However, because of their advanced ages and because of the slight language barrier with Mr. Martinez, wherever the Respondent pointed out actual inconsistencies or real weaknesses in their testimony, especially where the Respondent was able to weaken their testimony on cross-examination, I found in favor of the Respondent. For example, where a witness had problems recalling whether shots were given in the right or left knee, I found that the I.G. did not prove that the service was not performed, as claimed, when the Respondent listed one knee injection.

(b) that certain services listed on certain false claims were not provided as claimed. FFCL/29, 30.

Contrary to the Respondent's assertions, Catherine Arrington's testimony is not "riddled with inconsistencies" so as to make her entire testimony not credible. See, RB at p. 7. Quite the reverse is the case with regard to some important facts remembered quite clearly by Ms. Arrington, and these facts establish that the Respondent filed twenty-two (22) false claims.

For example, I find that Catherine Arrington's testimony with regard to the following is consistent, not controverted, and credible:

1. She never saw the Respondent after January, 1979 (TR II/89);

2. She only saw the Respondent six times (TR II 91, 97, 104;

3. She never had an EKG performed by the Respondent (TR II/90, 97, 104) (cf. TR II 143);

4. She never had an examination; she only received injections from the Respondent (TR II/93);

5. She never received two injections in the same day (TR II/103);

6. She never received an injection in the shoulder (TR II/93, 97, 99, 102, 103, 104);

7. She never received vitamin injections (TR II/97, 99, 104);

8. She was never in the Respondent's office for more than 7 to 8 minutes (TR II/92, 101) (cf. TR II/102)

On the other hand, with regard to FFCL/29, there was an inconsistency between some of the payment amounts listed on the I.G.'s Notice of Proposed Determination (I.G. Ex 9 ), which the parties stipulated were the amounts paid for the services alleged to be not provided as claimed, and the carrier's computer listing (I.G. Ex 82) which showed payments also. The computer listing indicated that the amount paid, which was the same amount shown on the Notice as having been paid for one service (such as an office visit or an injection) actually had been paid for two or more services. Thus, it was impossible to tell how much was paid to the Respondent for the service shown not to be provided as claimed. Also, the amounts paid in these instances substantially exceeded either the amount claimed for an item or the amounts paid in other instances

involving the same type of services. Thus, I determined the Inspector General had not proved the amounts paid where there were these inconsistencies.

With regard to FFCL/30, the I.G. failed to prove that certain services were not performed by the Respondent. Ms. Arrington's testimony about which knee she received an injection in was too confused and her testimony about frequency of office visits too vague, to accept as clear and convincing evidence. Also, where the type of injection was not legible on the claim, I assumed it might have been a knee injection and did not accept it as clear and convincing evidence.

B. Fannie May Jackson (Eighteen (18) Claims In Issue; Twelve (12) Proved False)

I find that the Respondent never gave Fannie May Jackson more than one injection in one day, and never rendered an extended office visit (i.e., never saw her for as long as 30 minutes). FFCL/35 a to e, 36. The I.G. did not prove that Fannie May Jackson did not receive (a) knee or shoulder injections; (b) a service coded as 7238; (c) standard-length office visits. FFCL/38. There was also an inconsistency between the amounts paid shown on the Notice of Determination (I.G. Ex 9) ( stipulated to by the parties) and the computer listing (I.G. Ex 82) similar to those described above regarding Ms. Arrington. For the same reasons I gave there, I concluded that the I.G. had not proved the payment for this false claim.

C. Enrique Martinez (Nine (9) Claims In Issue; Nine (9) Proved False)

I find that the Respondent never gave Enrique Martinez a knee injection and never gave him more than one injection the same day. For a discussion of Mr. Martinez's testimony, see, VII. B., infra.

D. Eva Pearson (One (1) Claim In Issue; It Was Not Proven To Be False) (Hearsay, Due Process, Confrontation, And Cross-Examination)

In essence, the Respondent argues that the I.G.'s use of unsworn hearsay statements attributed to Eva Pearson to establish that the Respondent presented or caused to be presented one (1) false or improper Medicare claim for payment (and received by the carrier prior to August 13, 1981) is unfair, that these statements are unreliable, uncorroborated, and not authenticated; the Respondent requests that such statements be given no probative value and that the claims to which they relate be dismissed. 19/ Due process arguments should always be considered seriously because "the right to be heard before being condemned to suffer grievous

19/ The Respondent makes the same argument for the 18 claims in issue that were received by the carrier after August 13, 1981 and discussed infra.

loss" is a basic principle of our law. Mathews v. Eldridge, 424 U.S. 319, 333 (1976), quoting Justice Frankfurter in Joint Anti-Fascist Refugee Comm. v. McGrath, 341 U.S. 123, 168 (1951). Moreover, the Regulations require that fundamental fairness will be employed in this action. (See, Regulations, §101.115(a), which requires the Administrative Law Judge to conduct a fair hearing.) Under the Act and Regulations, hearsay is admissible, but I agree that it must be credible and reliable and used in a fair manner to have any probative value. See, 5 U.S.C. §556(d); Catholic Medical Center v. NLRB 589 F 2d 1166 (2d Cir. 1978); Western Union v. FCC, 541 F. 2d 346, 353 (3rd Cir. 1976); cert. den. 429 U.S. 1092 (1977); DAVIS, Administrative Law Treatise, 2d Ed. 1978, Chapter 16, §§16.4 16.5 and 16.8. Also, an unsworn, uncorroborated statement is not as reliable as a sworn, corroborated or even a sworn, uncorroborated statement. Under the Regulations, and pursuant to Richardson v. Perales, supra, the primary burden is on the Respondent to locate (the I.G. having supplied the last known address), and subpoena the person who made the statement, if the Respondent wishes to confront and cross-examine that person. However, in this case, the I.G. listed Eva Pearson as a witness and subpoenaed her, but she did not respond to the subpoena and the I.G. was unable to produce her as a witness in time for the hearing. The I.G. did not ask that the hearing be continued to compel her attendance.

I find that Eva Pearson did give two statements to the carrier stating that she never saw the Respondent as a patient in 1981 and that an I.G. investigator, Barry Jerson, visited the witness and heard the same thing from her at a later time. TR II/52; TR III/120,121; I.G. Ex 95, 96. However, none of the statements are signed by Eva Pearson, she did not appear, even though she had been subpoenaed, and the I.G. did not attempt to enforce the subpoena or obtain a sworn statement from the witness. Accordingly, the I.G. has not proven that the one claim for service received by the carrier prior to August 13, 1981) is a false claim because there is not sufficiently convincing evidence that her unsworn statements are assuredly true. Pascal v. United States, 543 F. 2d 1284, 1289 (Ct. Cl. 1976).

Had any of the statements been sworn statements and had the witness been available for cross-examination by the Respondent, I would have had a better basis for determining whether her statements were reliable as to the truthfulness of their contents. 20/

20/ For example, if the I.G. had submitted a sworn statement, the I.G. had not listed Ms. Pearson as a witness, and the Respondent failed to attempt to cross-examine her, I might have had a basis for determining that her sworn statement supported findings asserted by the I.G., unless her sworn statement was weak or equivocal.

## VII. The I.G. Proved By A Preponderance Of The Evidence That The Respondent Knowingly Presented Or Caused To Be Presented Some (But Not All) Of The 46 Claims In Issue For Medicare Payment For Services That Were Not Provided As Claimed, From August 13, 1981 to April 11, 1983, In Violation Of The Act And Regulations

The I.G. proved by a preponderance of the evidence that the Respondent submitted false claims, for services that were not provided as claimed, in violation of the Act and Regulations. The following is a summary of each of the alleged false claims in issue here which were presented by the Respondent and received by the carrier on or after Agusut 13, 1981 and the reasons why they were or were not proven by a preponderance of the evidence to be false claims under the Act and Regulations:

### A. Eva Pearson (Eighteen (18) Claims In Issue; Eighteen (18) Not Proven False)

For the reasons given in Section VI D. of this Decision and Order, the 18 claims alleged to be false were not proven by the I.G. to be false. This is so even though the burden of proof for these 18 claims is by a preponderance of the evidence, rather than clear and convincing evidence which was the burden of proof for the one (1) Eva Pearson claim received by the carrier prior to August 13, 1981 discussed above. Even though the burden here is a lesser standard, I am reluctant to find that Eva Pearson's unsworn statements are true in light of the fact she failed to appear at the hearing when commanded to do so and did not sign a sworn statement.

### B. Enrigue Martinez Nine (9) claims In Issue; Six (6) Claims Proved To Be False For Nine (9) Services)

The reasons for finding that the I.G. proved by a preponderance of the evidence that the Respondent presented or caused to be presented to Medicare 6 claims for 9 services that were not provided to Enrique Martinez as claimed are (see, FFCL/39 a. to d, 40):

1. The Respondent never gave Mr. Martinez two (2) injections in one day.

2. The Respondent never saw Mr. Martinez in his office after November 28, 1980.

TR II/163, 165.

I was not persuaded by Mr. Martinez' repeated insistence that he

never received any injections. An investigation report attributed to a State Medicaid investigator quotes Mr. Martinez as stating that he received a shoulder injection which caused him a lot of pain. R Ex E; TR II/170-179. He also gave one statement to an I.G. investigator that he received a flu shot and contradicted that in another, later, statement and in his testimony. I.G. Ex 93, 94; TR II/166, 168. Although he insisted he never made the statement attributed to him by the State investigator and explained that his difficulty with the language caused him to give incorrect information in his first flu shot statement, I concluded that the I.G.'s proof with respect to the allegedly falsity of shoulder injections (no flu shots were claimed) claimed by Respondent fell short of meeting either burden of proof standard. (See, FFCL/44 where the I.G. did not prove that Mr. Martinez did not receive a shoulder injection on each of three claims.) I found the remainder of Mr. Martinez' testimony to be clear, unequivocal and credible.

C. Katherine Clinkscales (Nineteen (19) Claims For Twenty-Two (22) Services In Issue; Eighteen (18) Claims Proved False for Nineteen (19) Services)

The reason for finding that the Respondent presented 18 claims for 19 services that were not provided as claimed is that the Respondent never gave Ms. Clinkscales more than one injection on the same day. See, FFCL/31 a to o, 32. However, because she could not testify consistently about the part of her body in which she received injections, I did not accept as being proven false those claims listing only a single injection . See, FFCL/33, 34.

VIII. The Amount Of The Proposed Penalties (As Modified) And, Assessments (As Modified), And Length Of Suspension (As Modified) Are Reasonable And Appropriate Under The Circumstances Of This Case, Within The Meaning And Intent Of The Act And Regulations

Having concluded that the Respondent is liable for penalties, assessments, and a suspension in this case, because the I.G. proved liability and intent to defraud by clear and convincing evidence (for claims received by the carrier prior to August 13, 1981) and by a preponderance of the evidence (for claims received by the carrier on or after August 13, 1981), I must decide the appropriateness of said proposed penalties, assessments and suspension, as modified by the proof.

I have already stated what the Act and Regulations provide and concluded that the Respondent presented false claims. The maximum penalties, assessments and suspension which could be imposed here, as modified by the proof, are much greater than what the I.G. proposes, as modified by the proof. See, FFCL/54, 55.

A. There Exist Aggravating Factors

The Act and Regulations provide that, in determining the amount or scope of any penalty or assessment, the Secretary shall take into

account: (1) the nature of the claims and the circumstances under which false claims were presented; (2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims and (3) such other matters as justice may require. Guidelines are provided for determining appropriate assessments and penalties. See Regulations, §101.106. The Regulations require me to balance any aggravating against any mitigating factors. The Regulations provide that, where there are substantial aggravating circumstances, the amount of each penalty and assessment be set near or at the maximum amount. The regulatory guidelines are not binding on the ALJ. To determine the length of a suspension, the ALJ should consider the same guidelines outlined in Regulations §§101.106, 101.107. The Regulations also provide that these guidelines are not binding. Finally, the Regulations, §101.106(b)(4), provide that Respondent's resources will be considered.

I conclude that there exist aggravating factors in this case. Some are discussed earlier in this Decision and Order. The Respondent billed for substantial sums and had a high degree of culpability. The record demonstrates that the false claims in issue constitute a small portion of a broad pattern or scheme to defraud the Medicare program. Only one of these aggravating circumstances need exist for the Respondent's conduct to be deemed aggravating. The Inspector General has the burden of proving the existence of any such aggravating factors by clear and convincing evidence (for claims received prior to August 13, 1981) and by a preponderance of the evidence (for claims received on or after August 13, 1981). 45 C.F.R. §101.114(a)(b), 101.106(b).

Specifically, it has been proven that circumstances under which the claims in question were presented by the Respondent were flagrant. This justifies the imposition of a substantial penalty and assessment. The culpability of the Respondent is so great that it is tantamount to criminal intent. Also, justice requires that I consider the Respondent's efforts to cover up his scheme and his obstruction of the hearing in this case.

Section 101.106 of the Regulations provides:

> It should be considered an aggravating circumstance if such items were of several types, occurred over a lengthy period of time, there were many such items or services (or the nature and circumstances indicate a pattern of claims for such items or services), or the amount claimed for such items was sustantial.

In summary, a large number of claims were proven to be false, the Respondent's intent to defraud is evident from the record, the Respondent's scheme was systematic, the magnitude of the Respondent's scheme went well beyond this case, and the Respondent

obstructed the hearing in this case; each of these factors in itself would support the proposed imposition of penalties, assessments and a suspension of the Respondent in this case.

B. Rebuttal

The only rebuttal presented in this case was by way of cross-examination. The Respondent's counsel was successful in creating enough doubt in some instances so that the I.G. did not meet his burden of proof with regard to certain claims in issue and with regard to certain services in issue.

C. Mitigating Factors

I find that the total amount of the penalties and assessments are low in light of the record in this case, especially considering the aggravating circumstances and weighing them against any mitigating factors. But, I am reluctant to disturb the I.G.'s proposed amounts per each penalty and assessment because I feel that the I.G. is best equipped to make the decision regarding the extent of penalties and assessments, unless additional evidence damaging to the Respondent and previously unknown to the I.G. comes out at the hearing, or vice versa.

Knowing that the standards for determining the length of a suspension are different under the Act and Regulations with regard to the suspension proposed in this case, from the standards presented in Docket C-12, I find that a reduction is still warranted for the reasons stated in the Decision in Docket C-12, for the reason that the I.G. was unable to prove that a substantial number of claims and services in issue here were false claims and for the reasons stated in this Decision and Order in Section V, "The Respondent's Knowledge And His Intent To File False Claims," supra. Accordingly, I find and conclude that the suspension should correspond to the suspension in Docket C-12.

D. The Assessment, Penalty And Suspension Are Supported By The Record In This Case (After Modifications)

The I.G. requests that I order penalties of $138,800, assessments of $11,200, and a suspension for ten (10) years from the Medicare and Medicaid programs. See, FFCL/54, 55, 56.

I conclude that the Respondent shall be subject to penalties of $54,748.81, assessments of $2,311.67, and shall be suspended from participating in the Medicare and Medicaid programs for a period to run concurrently with the suspension proposed in Docket C-12 (i.e., until December 10, 1990). See, FFCL/54, 55, 56.

The penalties are intended to serve as a deterrent to future unlawful conduct by a particular Respondent or by other participants in the Medicare or Medicaid programs. In its report on the Act, 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, 9th Cong., 1st Sess. Vol. III, 327, 329. I conclude that penalties of $54,748.81 are a sufficient deterrent to the Respondent, based on the proof in the record.

The purpose of the assessments are to enable the United States to recover the damages resulting from false claims; this includes the reimbursement actually paid to the Respondent and the costs of investigating and prosecuting his unlawful conduct. The assessments are "in lieu of damages." The assessments enable the United States to recoup damages without having to assume the burden of establishing actual damages. 48 Fed. Reg. 38831 (Aug. 26, 1983).

Section 101.107 of the Regulations requires the same criteria used in determining penalties and assessments be considered in determining the length of any suspension imposed, including the presence of aggravating and mitigating factors; the purpose of the suspension is deterrence and protection of the Medicare and Medicaid programs. 48 Fed. Reg. 38832 (Aug. 26, 1983). The suspension imposed in this case is also a sufficient deterrent to the Respondent. based on the proof in the record.

## ORDER

Based on the evidence in the record and the Act and Regulations, it is hereby Ordered that the Respondent:

(1) pay penalties of $54,748.81

(2) pay assessments of $2,311.67; and

(3) be, and hereby is, suspended from the Medicare and Medicaid programs for a time to run concurrently with the suspension in Docket C-12, (i.e., to December 10, 1990) on the condition that, by October 10, 1990, the Respondent submit evidence satisfactory to the I.G. (1) that he is not, as of October 1, 1990, dependent on drugs or alcohol and (2) submit evidence that he has completed a seminar or program within that year on Medicaid and Medicare billing requirements that is approved or sponsored by New York State, the Federal Government or by the I.G. (In the event the Respondent submits this evidence to the I.G. and the I.G. does not respond to the Respondent by December 10, 1990, the Respondent is then automatically reinstated as of December 10, 1990.) If

this evidence is not submitted by the Respondent by October 10, 1990, the Respondent's suspension from Medicare and Medicaid programs will then be for the entire ten (10) year period proposed by the I.G. in this case, unless the Secretary reinstates the Respondent pursuant to another provision of federal law.

/s/

Charles E. Stratton
Administrative Law Judge