Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
The Inspector General,	)	Date: June 23, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-618
	)	Decision No. CR1808
Cary Frounfelter and Kast Orthotics and Prosthetics, Inc.,	)	
	)	
Respondents.	)	
	)	

DECISION

I find that Respondents, Cary Frounfelter (Mr. Frounfelter) and Kast Orthotics and Prosthetics, Inc. (Kast) presented or caused to be presented claims for payment to the Medicare program for medical or other items or services that they knew or should have known were false or fraudulent or not provided as claimed. The evidence in this case overwhelmingly supports the conclusion that Mr. Frounfelter and his company Kast systematically, fraudulently, and falsely claimed reimbursement under Part B of the Medicare program for orthotic devices which they knew or should have known were not eligible for compensation under Part B. I sustain the determination of the Inspector General (I.G.) to impose the following remedies, jointly and severally, against Respondents:

- A civil money penalty of $100,000;

- An assessment of $42,220; and

• Exclusion from participating in Medicare and all other federally financed health care programs, including State Medicaid programs, for a period of seven years.

I. Background

On August 1, 2007, Respondents filed a hearing request challenging the I.G.'s determination to impose the above-described remedies. The case was assigned to me for a hearing and a decision. I held a hearing in Tampa, Florida on March 10 and 11, 2008. At the hearing I received into evidence exhibits from the I.G. consisting of I.G. Ex. 1 - I.G. Ex. 105. I declined to receive I.G. Ex. 106. I received into evidence exhibits from Respondents consisting of R. Ex. 2 - R. Ex. 21. I also received the testimony of several witnesses. On March 24, 2008, I received additional testimony by telephone.[1] The I.G. and Respondents filed pre- and post-hearing briefs.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Respondents presented or caused to be presented reimbursement claims to Medicare for medical or other items or services that they knew or should have known were false or fraudulent or not provided as claimed; and

2. The remedies that the I.G. determined to impose are reasonable.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading and I discuss each Finding in detail.

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[1] The parties filed numerous motions prior to the hearing. I issued written rulings addressing these motions or ruled on them on the record of the hearing. I will not recapitulate my rulings here although I discuss some of them below, where appropriate, in the text of this decision.

1. Respondents presented or caused to be presented reimbursement claims to Medicare for medical or other items or services that they knew or should have known were false or fraudulent or not provided as claimed.

This case is brought pursuant to section 1128A of the Social Security Act (Act). The Act authorizes the imposition of remedies, including an assessment, a civil money penalty, and an exclusion against any individual or entity who presents or causes to be presented claims to Medicare for items or services that the individual or entity knew or should have known were false or fraudulent or not provided as claimed. Act, section 1128A(a)(1)(A), (B).

In this case there is overwhelming evidence proving that Respondents presented or caused to be presented Medicare reimbursement claims in violation of section 1128A. The evidence tells a simple and unadorned story of systematic fraud perpetrated by Respondents against Medicare.

Mr. Frounfelter is an orthotist who constructs, fits, and supplies orthotic devices used in the care and rehabilitation of individuals who have suffered from orthopedic or neurological injuries. In October 1997, Mr. Frounfelter incorporated Kast. I.G. Ex. 58, at 3; I.G. Ex. 59, at 4. Since then Kast operated as an independent supplier of items or services to the Medicare program. There is no dispute in this case that Mr. Frounfelter solely controls the management and direction of Kast and that the actions of Kast implement the decisions of Mr. Frounfelter. Under Mr. Frounfelter's management and direction Kast became a successful enterprise with about $2.5 million in annual revenue and about $400,000 in annual profits as of March 2006. I.G. Ex. 42D, at 21.

The 54 claims that are at issue in this case are claims that Respondents submitted to the Medicare program for reimbursement for orthotic devices that they supplied to Medicare beneficiaries who were inpatients of the HealthSouth Rehabilitation Hospital in Largo, Florida (Largo hospital). I.G. Post Hearing Brief Attachment 1, at 1-13.[2] The total dollar amount of these claims is $20,627.34. *Id.*; I.G. Ex. 58. The claims cover a period of alleged service delivery dates that runs about four and one-half years from December 16, 1999 through July 13, 2004. *Id;* I.G. Ex. 31B, at 4-5; I.G. Ex. 25B, at 4-5.

[2] The attachment is a summary of I.G. exhibits that are in evidence. Although I may cite to the attachment from time to time for purposes of brevity I make all of my fact findings from the exhibits which are summarized in that document.

Each of these claims is factually incorrect in that it claims a date for supply of an orthotic device that is later than the date when the Respondents actually supplied the device. I.G. Post Hearing Brief Attachment 1, at 1-13. That each of the 54 claims postdates the date when an orthotic device was supplied by Respondents becomes evident by comparing the date of alleged supply of an orthotic device on each claim with the date when the same item was provided as is stated in the records of the Largo hospital (hospital records). For example, the hospital records show that Respondents supplied an orthotic device on December 6, 2000 to a beneficiary known as M.S. I.G. Ex. 4C, at 12; I.G. Ex. 58, at 9. However, Respondents claimed that they provided the device to M.S. on December 28, 2000, more than three weeks after the date when they actually supplied the device. I.G. Ex. 4D, at 5, 6; I.G. Ex. 58, at 10.

The reason why Respondents postdated each of these claims is that they concluded that it was necessary to postdate the supply dates of orthotic devices to Largo hospital patients in order to convince Medicare to reimburse them directly for these devices. The uncontested evidence is that HealthSouth's management told Mr. Frounfelter that a condition for Kast being permitted by HealthSouth to provide orthotic devices to patients at the Largo hospital was that he and Kast would not bill the hospital directly for the items that Respondents provided to the hospital's patients. I.G. Ex. 42A, at 1; I.G. Ex. 42B, at 2; I.G. Ex. 42D, at 144, 146, 151, 153. Under their arrangement with HealthSouth Respondents had to bill Medicare for the orthotic devices they supplied to Largo hospital patients. I.G. Ex. 42D, at 149-150, 153. And, as I shall explain, Respondents knew that Medicare would not reimburse them directly for these devices unless Respondents convinced Medicare that the devices were supplied later than the dates of their actual delivery to patients.

As a general rule Medicare distinguishes between payments to institutional providers (hospitals and nursing homes, for example) for inpatient stays and payments to providers and suppliers for outpatient items or services. Typically, payments to institutional providers are made pursuant to Part A of the Medicare program. Part A reimbursement is a payment to the institutional provider covering all items or services included in a beneficiary's inpatient stay. In contrast payments made for outpatient items or services under Part B are generally made for the specific items or services for which payment is claimed.

No payment may be made under Part B of Medicare for any item or service that is covered under Part A. Act, section 1833(d). A provider or supplier may not lawfully claim reimbursement for an item or service under Part B if that item or service is already covered under Part A.

The general rule governing payment for an orthotic device that is furnished to a Medicare beneficiary during an inpatient stay is that payment is covered under Part A and not under Part B. Act, sections 1861(a) and 1861(s)(9). Generally, an orthotist who supplies an orthotic device to a Medicare beneficiary during the beneficiary's hospital stay may not claim reimbursement from Medicare under Part B but, rather, must seek compensation from the hospital.

Orthotics that are supplied to beneficiaries who are outpatients, as opposed to those beneficiaries who are inpatients, may be compensable under Part B. Also, there is an exception to the general rule prohibiting Part B reimbursement for orthotics supplied to inpatients. Medicare will accept a Part B reimbursement claim from a supplier such as Respondents for an orthotic device provided to a hospital inpatient *if* that item was ordered for the beneficiary's post-discharge in home use and *if* that item was supplied to the beneficiary within the two days prior to the date of the beneficiary's discharge from the hospital. I.G. Ex. 57, at 8-11. This exception is known informally as the "two-day" rule.

HealthSouth's refusal to pay Respondents for orthotic devices that Respondents supplied to the Largo hospital inpatients motivated Respondents to find a way to obtain Medicare Part B reimbursement for those orthotic devices. In order to convince Medicare that the orthotics for which they claimed reimbursement were legitimately compensable under Part B, Respondents claimed reimbursement for orthotics that they supplied to Largo hospital inpatients either: as if they had supplied the orthotics to these patients as outpatients after their discharge thereby qualifying the claims as claims for outpatient items or services; or as if they had supplied the orthotics to the patients within the two days prior to their discharge thereby qualifying the claims for reimbursement under the two-day rule.

Each of the 54 claims that are at issue in this case alleges either that the orthotic device for which reimbursement is claimed was supplied by Respondents to a Medicare beneficiary after the date of the beneficiary's discharge or within the two days prior to the beneficiary's discharge from the Largo hospital. I.G. Post Hearing Brief Attachment 1, at 1-13. The claimed, albeit false, date of service on each claim makes the claim appear to be legitimately compensable under Part B of Medicare.

For example, Respondents filed a claim for an orthotic device that they delivered to a beneficiary known as M.L., alleging that they had supplied the device to the beneficiary on December 11, 2000. I.G. Ex. 37B, at 4, 5; I.G. Ex. 58, at 32. The beneficiary had been an inpatient at the Largo hospital and his or her discharge date was November 21, 2000. I.G. Ex. 37A, at 2, 3: I.G. Ex. 58, at 32. In fact, the Largo hospital's records show that the orthotic device was actually supplied by Respondents to M.L. on or before

November 15, 2000, at least six days previous to the date of the beneficiary's discharge from the hospital. I.G. Ex. 37A, at 9; I.G. Ex. 58, at 31. Obviously, Medicare would have denied Respondents' Part B reimbursement claim for the orthotic device that Respondents supplied to M.L. had Respondents accurately reported to Medicare the date when they supplied the orthotic device. Respondents made it appear that their claim was compensable under Part B by claiming that they supplied the device after the date of M.L.'s discharge.

The inference that I draw from the pattern of discrepancies between Respondents' claims and the Largo hospital records is that Respondents systematically, deliberately, and falsely asserted that they supplied orthotics to Largo hospital inpatients within the two days prior to these patients' discharge or after their discharge in order to induce Medicare to pay their claims under Part B. This is an obvious fraud against the program because it induced Medicare effectively to pay twice for the same items, to the Largo hospital under Part A as part of the hospital's fee and, to Respondents under Part B. Each of the 54 claims that is at issue here, therefore, is a violation of the prohibition against intentional submission of false or fraudulent claims stated at section 1128A of the Act.

Respondents challenge the credibility of the evidence on which I base this conclusion. They argue that the Largo hospital's records are inherently unreliable because HealthSouth defrauded Medicare by pocketing Part A reimbursement monies that it should have distributed to suppliers like Respondents. I find this argument to be unpersuasive. HealthSouth may have engaged in illegal conduct and, indeed, that conduct is the subject of a settlement agreement between HealthSouth and the United States Department of Justice acting on behalf of the United States.[3] However, had HealthSouth wanted to perfect a fraud against Medicare it would have made its records consistent with Respondents' records so that the dates of supply on both sets of records supported Part B Medicare claims by Respondents. The dates of supply stated in the Largo hospital records are in fact, not in HealthSouth's interest and even support allegations of unlawful conduct by HealthSouth. By contrast, the dates stated in Respondents' claims clearly are in Respondents' interest given that they were attempting to obtain Part B reimbursement for those claims. For that reason I find HealthSouth's records to be more credible than Respondents' records.

[3] I discuss some of the ramifications of that agreement at Finding 2 of this decision.

Respondents argue also that their claims records reflect their practice of "switching" "stock" orthotics that they supplied to beneficiaries as inpatients, with customized orthotics, including ankle-foot orthotics, which they supplied to these same beneficiaries while they were outpatients. Thus, Respondents suggest that their claims are actually for the customized orthotics that they supplied after beneficiaries completed their stays at the Largo hospital and are not claims for the stock orthotics that they supplied to these beneficiaries while they were inpatients.

This argument is unsupported by credible evidence. Respondents have not offered probative evidence that proves specifically that, with respect to each of the 54 claims that are at issue, they provided a customized orthotic to the beneficiary as an outpatient. In their pre-hearing brief Respondents relied mainly on the written declaration of Mr. Frounfelter as support for this contention. But, Respondents did not offer that declaration into evidence and Mr. Frounfelter did not testify at the hearing.

Several of the beneficiaries whose care is covered by some of the 54 claims that are at issue here or their immediate family members denied under oath that Respondents had switched stock for custom made devices and I find their testimony to be entirely credible on this issue. Tr. at 327-329; 349-365.

In fact, the evidence strongly supports the inference that Respondents fabricated patient records in order to justify their Part B reimbursement claims and to make it look as if they had switched out devices after patients were discharged from the Largo hospital. The Largo hospital records for a patient known as "G.J." show that the he received his orthotic device from Respondents on February 23, 2003. I.G. Ex. 8D, at 8-9. He was discharged from the hospital on February 26, 2003. *Id.* at 2-3. However, Respondents claimed that they provided him with his orthotic device on March 12, 2003. I.G. Ex. 8E, at 4, 6. G.J. testified credibly that Respondents had not provided him with a second device after his discharge from the hospital and so, Respondents' reimbursement claim for the device that they supplied to him is patently false. I.G. Ex. 8A, at 2-3; Tr. at 327-329. But, it is also evident that Respondents fabricated records in order to justify their false reimbursement claim for the orthotic device that they supplied to G.J. Respondents' patient notes aver that, on March 10, 2003, they replaced G.J.'s orthotic due to a "terrible infection" caused by the previously-supplied device. That assertion is contradicted by G.J.'s testimony and is unsupported by any clinical evidence.

Additional evidence that Respondents' assertion that they switched devices is false emerges from the testimony of a former employee of Kast who averred credibly that he had never used, nor had he ever seen Mr. Frounfelter use, a stock or off the shelf ankle-foot orthotic device. I.G. Ex. 54A, at 2.

In their post-hearing brief Respondents asserted that the I.G.

> elected to completely discount the veracity of information contained in the Kast patient files, which often included Mr. Frounfelter's (or other technician's) detailed notes regarding patient care that documented that many of the questioned . . . services were delivered in an appropriate and legal timeframe, and indeed complied with Medicare's [two-day rule].

Respondents' post-hearing brief at 12. But, Respondents have cited to nothing – including their own records – that supports this assertion. *See id.*

Moreover, the preponderance of the evidence establishes to be unreliable any corroborative records that Respondents may have generated to support their reimbursement claims. As I discuss above, Respondents generated a false record for G.J. to justify claiming reimbursement for an orthotic device that they never supplied to that individual. There are other aspects of Respondents' records that support an inference that they were fabricated in order to support Respondents' false reimbursement claims.

For example, a patient identified as "J.R." was discharged from the Largo hospital on December 3, 1999. I.G. Ex. 31A, at 2, 3. The Largo hospital's records show that Respondents supplied an orthotic device to J.R. on November 19, 1999, about two weeks prior to the patient's date of discharge. *Id.* at 12. Clearly, Respondents should have sought reimbursement for the device from the Largo hospital out of the hospital's Part A reimbursement for the care it provided to J.R. However, Respondents claimed that they provided the device to J.R. on December 16, 1999, nearly a month after the date when they actually provided it. I.G. Ex. 31B, at 4, 5. In an evident attempt to support that claim Respondents generated a patient note that is dated December 16, 1999, which states as follows:

> Fit and delivered ROM K/O. Set patient @ 30 degree flex and 60 degree ext. F/u as Dr. Near request.[4]

I.G. Ex. 31B, at 3.

[4] The note is initialed "CFF" and I infer that these initials were put there to indicate that Mr. Frounfelter had personally reviewed and approved the note.

On its face the note suggests that Respondents delivered an orthotic device to J.R. on December 16, 1999, two weeks after the patient's discharge from the hospital. The note, if true, would support Respondents' claim that they had delivered a device to J.R. after the patient's discharge that was different from the one which they supplied to the patient at the hospital and it would justify claiming reimbursement for the device under Part B.

However, on November 30, 1999, while J.R. was still an inpatient at the Largo hospital Mr. Frounfelter entered a strikingly similar note in the patient's hospital record. That note, which is written and signed by Mr. Frounfelter, states:

> Set patient's ROM to Dr. Near's requirements 30 [degree] Ext 60 [degree] flex. Will adj. if Dr. Liles requires different ROM.

I.G. Ex. 31A, at 8.

The evident similarities between the two notes (they use identical numbers for range of motion although the first provides for 30 degrees of flexion and 60 degrees of extension and the second provides for 60 degrees of flexion and 30 degrees of extension) suggest that one simply was copied from the other but utilizing a different date. Moreover, neither note corresponds with nor explains a physician's order on November 18, 1999, for an orthotic device to be supplied to patient J.R. I.G. Ex. 31A, at 6. The two notes appear to refer, in fact, to care that was either not provided at all by Respondents or which Respondents provided on a date that was earlier than the date on either note.

Respondents offered no explanation for the similarities between the two notes or the inexplicable time lapse between the physician's orders and the asserted dates of treatment stated in the notes. Absent any explanation by Respondents I conclude that the notes were concocted by them to support their false claim.

Respondents contend also that on occasion they supplied orthotic devices to beneficiaries within two days of their planned discharges from the Largo hospital but that complications or other reasons caused these beneficiaries to remain in the hospital beyond their intended discharge dates. Respondents suggest that they should not be held liable for claims that they submitted under Part B for these beneficiaries because they made these claims in good faith.

There is no persuasive evidence establishing that any of the beneficiaries whose care is the basis for the 54 claims that are at issue in this case fall into the category of beneficiaries described by Respondents. For reasons that I explain above, I find Respondents' own records to be unreliable and, in several instances, to have been fabricated. Respondents have not offered any other credible evidence to corroborate their

assertions. Moreover, Respondents would not be excused from liability even if their assertions were true. There is simply no credible evidence to suggest that Respondents actually believed in good faith that they could claim reimbursement under Part B for orthotic devices supplied to patients whose stays in the Largo hospital were prolonged for unforeseen reasons.

Since the inception of this case Respondents have argued that they are not liable for any violation of section 1128A because they were induced by HealthSouth to file claims under Part B or because they relied on the advice of HealthSouth's management to file such claims. Respondents liken their assertion to that of a supplier who relies on the advice of legal counsel before filing a claim. According to Respondents a supplier who relies on advice of counsel is exonerated from liability if the advice turns out to be incorrect. And, according to Respondents, even if HealthSouth was not technically their counsel, they assumed that HealthSouth's guidance was reliable given HealthSouth's stature and the size of its operations.

I find this argument to be wholly without merit.[5] To begin with, neither HealthSouth nor the Largo hospital represented Respondents' interests. Their relationship with Respondents was an arms-length business relationship.

Respondents knew that they had no right or reason to rely on advice they may have received from HealthSouth. When Mr. Frounfelter completed an application for Kast to become an approved Medicare supplier on December 2, 1997, he acknowledged that he was familiar with and agreed to abide by the Medicare laws and regulations that applied to him and his business. I.G. Ex. 69. Respondents, as independent Medicare suppliers, are responsible for complying with Medicare reimbursement requirements and laws governing the honesty of claims. They have a responsibility to assure that they are acting lawfully and they may not hide behind the advice of other providers or suppliers to excuse them from discharging that responsibility.

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[5] In rulings that I made prior to the hearing I denied Respondents' subpoenas for witnesses whose testimony Respondents claimed would have supported their "reliance on HealthSouth" theory for the reason that such testimony was patently irrelevant. *See* Rulings on Parties' Motions, March 4, 2008. However, for purposes of this decision I accept Respondents' assertions that such witnesses, if called, would have testified that they told Respondents that filing claims under Part B for all orthotics that Respondents supplied to the Largo hospital inpatients was legal. For the reasons that I explain in this decision Respondents had no basis for relying on such advice and, indeed, had every reason to disregard it.

Furthermore, any suggestion by HealthSouth to Respondents that they could legitimately claim reimbursement under Part B for orthotics that they supplied to Largo hospital inpatients would have been so transparently self-serving that Respondents should have recognized its obvious lack of credibility. Medicare put Respondents on notice precisely as to their obligations for filing claims that were honest and legitimate. Respondents received manuals from Medicare that specified their obligations concerning the claims they submitted. I.G. Ex. 42D, at 115-116. Mr. Frounfelter merely needed to read them to recognize instantly that the purported advice given by HealthSouth was wrong.[6] On more than one occasion Medicare issued statements to suppliers including Respondents explaining exactly how the two-day rule operated. I.G. Ex. 57, at 9.

Any arguments Respondents now make about not understanding their obligations or being misled to make good faith errors are belied by admissions they made previously. Mr. Frounfelter was first interviewed by agents of the I.G. on May 20, 2004. I.G. Ex. 42A, at 1. In that interview he admitted that he had agreed, as a condition for doing business with HealthSouth, to bill Medicare under Part B for items that he supplied to HealthSouth inpatients. *Id.* He stated that he knew that the manner in which billing was being performed was wrong and illegal but that he did so because all the patients were going to HealthSouth and because billing in this manner was necessary in order to feed his family. *Id.*[7]

In testimony that Mr. Frounfelter gave on March 1, 2006 in response to an investigational subpoena, he recanted this admission by asserting that he thought that billing Medicare Part B directly for orthotics that he supplied to Largo hospital inpatients was correct because "they were a whole different type of facility [a rehabilitation hospital and not an acute care hospital]" and "[b]ecause everybody in the county was going there." I.G. Ex.

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[6] Mr. Frounfelter averred that he had not read these manuals. I.G. Ex. 42D, at 115-116. Failure by a supplier to read informational and advisory material supplied to him or her by Medicare is no excuse for failure to comply with the program's claims requirements.

[7] Respondents have averred at times that the I.G. agents who participated in this initial interview of Mr. Frounfelter are not credible and that their report of the interview is false. I find no evidence to support this assertion. I.G. agent Christian Jurs, one of the two agents who participated in the initial interview, was cross examined by Respondents' counsel. Tr. at 46-115. There is nothing in his testimony that is inconsistent with the initial interview of Mr. Frounfelter. Respondents did not cross examine the other I.G. agent who was present at the interview although the I.G. made him available for cross examination.

42D, at 154. He contended that he thought that Largo hospital qualified for an exception to the two-day rule due to the type of care that it provided. *Id.* at 158. I find these statements not to be credible. If Respondents thought that billing Medicare Part B for the orthotics that they supplied to inpatients at Largo hospital was legitimate they would have had no need to falsify the dates on which they supplied these devices.

Mr. Frounfelter also asserted, in testifying in response to the investigational subpoena, that the dates of supply on his reimbursement claims for Largo hospital inpatients were actually the dates of follow up visits that he made personally to these patients' homes after their discharge from Largo hospital. He asserted that his understanding of Medicare reimbursement requirements was that he could bill under Part B for items supplied to an inpatient if he made a follow up visit to the patient after his or her discharge from the hospital to assure that the orthotic device fit correctly. I.G. Ex. 42D, at 161-165. I find this assertion to be preposterous. There is nothing in Medicare reimbursement documents which Respondents can point to that even remotely supports their interpretation of reimbursement requirements (and, indeed, Respondents have identified nothing which even purportedly does). Nor have Respondents offered as evidence persuasive documentary proof of these asserted post-discharge visits as respects the 54 claims that are at issue here. As I discuss above, Respondents' purported treatment records are unbelievable.

Respondents argue that they should be excused from any liability for filing false or fraudulent claims because the I.G. was aware for years about HealthSouth's activities and failed to act aggressively to stop them.[8] They contend that the I.G.'s knowledge that HealthSouth, or more specifically, the Largo hospital, refused to pay suppliers out of Part A reimbursement establishes that Respondents' claims were not false, fictitious, or fraudulent and that Respondents lacked the necessary intent to defraud Medicare. Respondents contend that the United States Court of Appeals for the Fifth Circuit's decision in *United States v. Southland Management Corp., et al.,* 326 F.3d 669 (5th Cir. 2003), supports their argument. Respondents' post-hearing brief at 6-12.

In that case the United States Department of Housing and Urban Development (HUD) had a contract with a property management company to operate rental apartments for the benefit of low income tenants. The contract provided for monthly housing assistance payments to the management company in return for the company's promise to maintain

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[8] As factual support for this contention Respondents rely on the failure by the I.G. to act immediately on complaints made by orthotists other than Respondents concerning HealthSouth's refusal to pay them out of their Part A reimbursement. Respondents' post-hearing brief at 9-11.

the property in "decent, safe, and sanitary" condition. The contract allowed for abatement of assistance payments by HUD if it determined that the property was not being maintained pursuant to contractual requirements. For several years HUD inspected the property annually and concluded that the property was not being maintained adequately. It repeatedly gave notices to the management company concerning the deficiencies that were identified at the property and provided it with lists of corrective actions that it determined that the management company needed to take. However, it also did not abate assistance payments. Ultimately, the United States Attorney filed a civil action under the False Claims Act, 31 U.S.C. § 3729, against the management company, alleging that the company's certifications on their vouchers that they submitted falsely stated that the property was decent, safe and sanitary.

The Fifth Circuit held that the management company was entitled to the payments it sought. Therefore, its certifications were not false. That was, according to the court, because the specific language of the contract between the management company and HUD entitled the management company to be paid for the claims it made despite their certifications that the property was decent, safe and sanitary. The court held that the contract explicitly provided a remedy for a breach: when the management company was notified by HUD that it failed to maintain the property in a decent, safe, and sanitary condition, and that corrective action must be taken, the management company continued to be entitled to payment during the corrective action period and until HUD notified it in writing that it had failed to take the necessary corrective action. In the opinion of the court, the voucher certifications filed by the management company simply were immaterial to enforcement of the contract and therefore, nothing that the management company said in its vouchers constituted a material falsehood.

The court also noted a continuing course of conduct between HUD and the management company which it found demonstrated that both HUD and the management company regarded that it was entitled to receive continuing housing assistance payments despite the substandard condition of the property. The court observed that there was significant evidence during the period in question that the property was increasingly uninhabitable but that HUD wanted the management company to continue to run the property and to attempt to improve its condition.

Southland is distinguishable from this case on several grounds. Most obviously, the facts here have no similarities to the relationship described in *Southland*. The essence of the *Southland* decision was that the specific language of the contract between HUD and the management company superseded any more generally stated voucher filing requirements. Nothing in Medicare reimbursement regulations or in the relationship between Respondents as suppliers and Medicare remotely resembles that contract.

Furthermore, there is no course of conduct here that resembles the course of conduct in *Southland*. In *Southland* HUD was aware that the management company was failing to meet HUD requirements but, effectively, waived those requirements for a time because it determined that the management company's continued operation of the property was in the interest of tenants and HUD. Here, there is not even a suggestion that Medicare knew about Respondents' false claims but decided to pay them anyway based on a determination that to do so would benefit Medicare or its beneficiaries. In this case, Medicare was induced by Respondents to pay for items that should have been covered in the Part A reimbursement that it gave to the Largo hospital. There is no conceivable benefit to Medicare from that arrangement.

Finally, there is no evidence that Medicare or the I.G. condoned HealthSouth's or Respondents' actions. The court in *Southland* found that HUD actively condoned the management company's continued operation of the property in question by encouraging it to improve and by continuing to make assistance payments to it. Here, the evidence shows only that the I.G. responded slowly to complaints about HealthSouth. A slow response to complaints is in no sense equivalent to actively condoning unlawful activities.

2. The remedies that the I.G. determined to impose are reasonable.

Section 1128A establishes three distinct remedies that the I.G. may impose against any individual or entity who violates the Act's prohibitions against willfully filing false or fraudulent claims. These remedies include: a civil money penalty of not more than $10,000 for each item or service for which reimbursement is falsely or fraudulently claimed; an assessment of not more than three times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim; and exclusion from participation in Medicare and all health care programs described at section 1128B(f)(1) of the Act including State Medicaid programs. Act, section 1128A(a). The Secretary of the United States Department of Health and Human Services published criteria for determining remedies imposed pursuant to the statutory authority of section 1128A and these are stated in 42 C.F.R. Part 1003.

I have evaluated the I.G.'s proposed remedies de novo and pursuant to the regulatory criteria. I find these proposed remedies to be reasonable.

a. A civil money penalty of $100,000 is reasonable.

The maximum civil money penalty that the Act permits in this case totals $540,000 (54 false or fraudulent claims x $10,000 per claim). The I.G.'s proposed civil money penalty of $100,000 is less than 20 percent of the allowable maximum. I find a penalty

of $100,000 to be entirely reasonable based on Respondents' fraud and their culpability and the notable absence of mitigating evidence. Indeed, a penalty of $100,000 is actually quite modest in light of the blatant fraud that Respondents perpetrated.

The regulatory factors which govern the amount of a civil money penalty imposed pursuant to section 1128A are stated at 42 C.F.R. § 1003.106(a)(1). Not all of them are relevant to this case. I find that those which potentially are relevant here include: the nature of Respondents' claims or other wrongdoing and the degree of Respondents' culpability; Respondents' financial condition; and such other factors as justice may require. *Id.*

The regulation also describes mitigating and aggravating factors which should be taken into consideration in applying the criteria for determining penalty amounts. It is an aggravating factor if the nature of the claims or the circumstances show a pattern of false or fraudulent claims, if the claims were filed over a lengthy period of time, or if the amount claimed was substantial. 42 C.F.R. § 1003.106(b)(1). It is a mitigating factor if the claims were all of the same type, there were few false claims, they occurred within a short period of time, or the total amount claimed is less than $1,000. *Id.* Knowingly filing a false or fraudulent claim is an aggravating factor. 42 C.F.R. § 1003.106(b)(2). Prompt correction of false claims practices is a mitigating factor. *Id.*

The evidence in this case establishes the presence of aggravating evidence that relates to the nature of the 54 false and fraudulent claims that Respondents presented or caused to be presented and to their culpability. First, there is an evident pattern of false and fraudulent claims and those claims were filed by Respondents over a lengthy period of time. Respondents consistently and consciously misstated the dates when they provided orthotic devices to Largo hospital inpatients in 54 instances over a period of about four and one-half years. Second, the dollar amount of the false claims in this case – more than $20,600 – is substantial.

Respondents attempt to minimize the impact of their false claims activity by comparing it against the overall, arguably illegal, activities of HealthSouth. I find this to be an inapt comparison. There is no question that HealthSouth is a much larger entity than Kast and I am willing, for purposes of this decision, to accept as true the assertion that the scope of its arguably unlawful activities may have been much greater than those of Respondents. But, Respondents' fraud is not diminished in any respect by what HealthSouth may or may not have done.

Respondents assert also that the claims at issue were all of the same type and were filed over a short period of time. They certainly were not filed over a short period of time as is evidenced by the fact that they span a period of about four and one-half years. And, I disagree with Respondents' characterization that the claims were all of the same type. They were similar only in the nature of the fraud that Respondents committed and in the general nature of the items (orthotic devices) for which Respondents claimed reimbursement. But, each claim was unique in that it was for a distinct, individualized orthotic device. And, the false information that Respondents generated to support each claim was uniquely developed by them in the context of that claim. In other words, each of the 54 claims at issue constituted a separate and individualized act of fraud that was part of a larger pattern of fraudulent activity by Respondents.

As to Respondents' culpability, it is evident that they knowingly and intentionally defrauded the Medicare program over a lengthy period of time. This is not a case of negligent claims filing or even of filing claims with disregard to the truth of their contents. Rather, it is a case in which Respondents consciously set out to defraud the Medicare program in order to obtain reimbursement directly from Medicare which they knew they were not entitled to receive. The intentional quality of Respondents' actions is underscored by their falsification of patients' records in order to support their false and fraudulent claims. It is underscored also by the fact that Mr. Frounfelter, early in the investigation into Respondents' conduct, admitted that he knew that what he and Kast were doing was unlawful.

Respondents deny any intent to file false or fraudulent claims. They assert that they relied – albeit improvidently – on the assurances provided to them by representatives of HealthSouth that filing claims for Part B reimbursement was appropriate under the circumstances. I have discussed this argument previously in addressing the issue of Respondents' liability. It is unnecessary that I revisit it here in depth except to say that I find it to be unbelievable. Respondents were not innocent bystanders to the fraud of another entity nor were they led naively into filing false claims. The overwhelming evidence in this case establishes that they eagerly did business with HealthSouth and knowingly entered into a corrupt bargain with that entity that had as its centerpiece filing false and fraudulent claims with Medicare.

Respondents have not averred that their financial condition precludes them from paying a civil money penalty of $100,000. However, had they made such an argument, I would not find this amount to be unreasonable in light of the amount of Kast's annual business.

Respondents argue that the civil money penalty (and the other remedies as well) should be mitigated because they provide items or services of a very high quality, and promptly, to Medicare beneficiaries. I accept as true Respondents' representations of the quality and promptness of the items and services that they provide. But, Respondents have not proven that penalizing them, or for that matter, excluding them from participation, will have an adverse impact on Medicare beneficiaries or on the program itself. There is nothing in the record to suggest that other suppliers of orthotic devices in Respondents' community are incapable of filling any gaps created by the remedies that I impose.

Respondents have, at times during this case, asserted that there is additional mitigating evidence. I find these assertions to be without merit. Respondents asserted in their pre-hearing brief that they had cooperated with the government during the investigation into HealthSouth's activities. I find that there is no proof to substantiate this claim. Respondents also asserted in their pre-hearing brief that they ceased to file false or fraudulent claims immediately upon first being interviewed by the I.G.'s agents. They provided no proof to support this assertion and there is evidence to the contrary in the record. Tr. at 70-71.

Respondents contended also in their pre-hearing brief that they terminated any activities that could be construed as fraudulent once they ceased doing business with HealthSouth. That may be so, but I do not find it to be a mitigating factor because it was the relationship between HealthSouth and Respondents that *generated* the fraud established in this case. That Respondents may not have engaged in fraud as a consequence of their relationship with other providers after their relationship with HealthSouth ended is not, in and of itself, a reason to find the fraud emanating from the HealthSouth relationship to be any less egregious. Respondents also contended in their pre-hearing brief that they realized no "increased profit" as a consequence of their fraud. I find this assertion to be unclear. What is absolutely clear here, however, is that Respondents benefitted enormously from their relationship with HealthSouth because their willingness to play ball with HealthSouth provided them with access to a steady stream of highly lucrative business.

b. An assessment of $42,220 is reasonable.

Regulations governing the amount of an assessment reiterate that the I.G. may impose an assessment in an amount of up to three times the amount that is falsely claimed. 42 C.F.R. § 1003.104(a)(2). An assessment is intended to be a remedy that is in lieu of the damages sustained as a result of false or fraudulent claims. 42 C.F.R. § 1003.104(b). The regulatory factors which apply in determining civil money penalty amounts apply to determining assessments as well. 42 C.F.R. § 1003.106(b).

The proposed assessment in this case of $42,200 is slightly more than double the amount falsely claimed by the Respondents and is well within the allowable maximum assessment amount. I find it to be reasonable given the aggravating evidence that I discuss at subpart a. of this Finding and the absence of mitigating evidence.

Respondents argue that any assessment in this case is precluded by a settlement between the United States and HealthSouth of alleged False Claims Act or section 1128A violations by that entity (Healthsouth settlement). The settlement agreement, which is Attachment 2 to the I.G.'s post-hearing brief, settles claims that the United States may have against HealthSouth in return for a payment to the United States by HealthSouth of $4,000,000. I.G. Post Hearing Brief Attachment 2, at 4. A schedule attached to the settlement agreement includes the Largo hospital as a facility covered under the agreement. *Id.* at 27.

Respondents argue that to collect an assessment from them in light of the HealthSouth settlement amounts to what they characterize as a "double recovery." They assert that the HealthSouth settlement was intended to cover all of the allegedly unlawful orthotics and prosthetics billings practices engaged in by HealthSouth. Consequently, according to Respondents, to impose an assessment against them to cover the damages sustained by Medicare in this case would be unfair and unlawful and would result in an impermissible windfall to the United States. Respondents' post-hearing brief at 2.

I do not find this argument to be persuasive. First, the damages sustained by Medicare as a consequence of Respondents' false and fraudulent claims are not limited exclusively to the payments made to Respondents for those claims. Here, damages include those costs, but they also include the substantial costs of investigating Respondents' fraud and of bringing Respondents to justice.[9] They also include the inchoate cost to the reputation of the Medicare program caused by Respondents' perpetration of their fraud.

This proceeding against Respondents has as its overall objective the protection of the Medicare program. That objective transcends simply collecting money damages from Respondents to compensate Medicare for its payments for false and fraudulent claims. The investigation and litigation costs necessary to attain that objective justify an

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[9] This case is the culmination of an investigation that began several years ago. Pre-hearing proceedings in this case consumed several months. There were numerous motions filed by the parties. The hearing itself lasted two days plus additional telephone hearing time. The I.G. paid to transport counsel and several witnesses to the Tampa, Florida hearing site from locations that were as far away as Hawaii and Washington, D.C.

assessment of the amount proposed even if the HealthSouth settlement made Medicare financially whole for all of the payments it made to Respondents as a result of their false and fraudulent claims.

Respondents are not parties to the HealthSouth settlement agreement so they cannot claim the benefit of its terms. The agreement exempts *HealthSouth* from further liability to the United States for its possibly false or fraudulent reimbursement claims in return for HealthSouth's payment of $4,000,000. But, not only does the agreement not suggest that the payment covers the exact dollar amount of the United States' losses, it specifically reserves to the United States the right to bring actions against third parties who are not parties to the HealthSouth settlement agreement. I.G. Post Hearing Brief Attachment 2, at 12 (Paragraph O.). The HealthSouth settlement agreement additionally provides that no individuals other than HealthSouth and certain other named parties are released by it. *Id.* at 4-5 (Paragraph C.).

Furthermore, it cannot be concluded reasonably that an assessment paid by Respondents would amount to a double payment to the United States for Respondents' false and fraudulent claims or a windfall. That is because it is impossible to determine whether the HealthSouth settlement actually made the government whole for all of the false claims activity generated by or related to HealthSouth's operations.

It is entirely consistent with the terms of the HealthSouth settlement agreement to conclude that the lump sum payment agreed to by HealthSouth settled the case without any accounting of the actual damages sustained by the United States. There is nothing in the HealthSouth settlement agreement that suggests that the settlement which HealthSouth agreed to pay equaled the exact dollar amount of the losses sustained by the United States or renders the United States whole as a consequence of false claims filed against it by HealthSouth or by orthotics suppliers.

c. An exclusion of seven years is reasonable.

The purpose of any exclusion of a provider or supplier from participating in Medicare and other federally financed health care programs is to protect these programs and their beneficiaries and recipients from individuals and entities who have been established to be untrustworthy. An exclusion thus serves a purpose that is entirely separate from financial remedies that are designed to compensate programs for their losses or for the costs of maintaining program integrity. An exclusion is designed to protect against *future* misconduct.

The regulations provide that an exclusion for violation of section 1128A should be premised on the same factors and potentially aggravating and mitigating evidence that pertain to penalties and assessments. 42 C.F.R. § 1003.107(a). I have previously discussed the aggravating evidence in this case and it is unnecessary that I discuss it again here. Suffice it to say that it establishes that Respondents are extraordinarily untrustworthy providers for which exclusions of seven years are certainly merited. These Respondents engaged in a concerted and sophisticated scheme to defraud the Medicare program extending over a period of years. There is nothing in the record to suggest that they would have ceased their fraud but for the I.G.'s investigation of it. I have no doubt that Respondents would have continued to engage in it had it remained undetected.

/s/
Steven T. Kessel
Administrative Law Judge