Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of: The Inspector General, - v. - Berney R. Keszler, M.D., and Berney R. Keszler, M.D., P.A., Respondents.	DATE: November 1, 1990 Docket No. C-167 Decision No. CR107

DECISION

Respondents requested a hearing to contest the Inspector General's (I.G.) proposed imposition against them, jointly and severally, of civil monetary penalties of $390,000.00, assessments of $148,843.54,[1] and a ten year exclusion from participation in the Medicare, Medicaid, Maternal and Child Services Block Grant, and Social Services Block Grant programs (Titles XVIII, XIX, V, and X of the Social Security Act, respectively).[2] The I.G. alleged that Respondents violated section 1128A of the Social Security Act (the Act), as implemented by 42 C.F.R. 1003.100 et seq.

I held a hearing in Lufkin, Texas, on April 23-26, 1990. Based on the law, regulations, and evidence adduced at the hearing of this case, I conclude that Respondents unlawfully presented or caused to be presented 260 claims

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[1] On April 5, 1990, the I.G. made a motion to amend the index of claims to correct minor errors discovered in its September 15, 1989 Notice letter. The I.G. sought to raise the stated assessment figure from $148,843.54 to $148,849.54. Respondents have not objected, so I now grant that motion.

[2] For the sake of brevity, for the remainder of this decision I will use the term "Medicaid" to refer to the Medicaid, Maternal and Child Services Block Grant and Social Services Block Grant programs.

for items or services in violation of the Act. I impose penalties of $150,000.00 and assessments of $100,000.00 against Respondents, jointly and severally. I also exclude Respondents from participating in Medicare and Medicaid for 10 years.

ISSUES

The issues in this case are whether:

1. Respondents presented or caused to be presented claims for items or services in violation of section 1128A of the Act.

2. Assessments, penalties, and exclusions should be imposed against Respondents and, if so, in what amounts or for what period of time.

3. The assessments, penalties, and exclusions imposed in this case violate Respondents' rights not to be placed in double jeopardy.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. At all times relevant to this case, Respondent Berney R. Keszler, M.D., (Respondent Keszler) was an anesthesiologist licensed to practice medicine in the State of Texas. Stip. 11. [3]

2. At all times relevant to this case, Respondent Berney R. Keszler, M.D., P.A. (Respondent Keszler, P.A.) was a professional association under the Texas Professional Association Act. Stip. 11.

3. At all times relevant to this case, Respondent Keszler was the sole owner and proprietor of Respondent Keszler, P.A. R. Ex. 76.

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[3] The parties' exhibits and the transcript of the hearing will be cited as follows:

I.G. Exhibit	I.G. Ex. (number)/(page)
Respondent Exhibit	R. Ex. (number)/(page)
Transcript	Tr. at (page)
Stipulations of Fact	Stip. (number)

4. The claims at issue in this action relate to anesthesia services performed at Memorial Medical Center of East Texas (Memorial Medical Center). Stip. 16., Tr. at 725, 727-729.

5. Respondent Keszler was issued a Medicare provider number, Number 00NL838, which was in effect at all times pertinent to this action at all times prior to July 28, 1987. Stip. 12.

6. Respondent Keszler was issued a Medicaid provider number in effect at all times pertinent to this action at all times prior to July 28, 1987. Stip. 12.5.

7. At all times pertinent to this action, Blue Cross and Blue Shield of Texas, Inc. (Blue Cross) was the fiscal agent for the Medicare program in the State of Texas, responsible for processing and reimbursing Medicare claims, and otherwise administering the Medicare program in Texas. Stip. 8.

8. At all times pertinent to this action, the Texas Department of Human Services (Medicaid) was the authorized State Medicaid Agency in the State of Texas responsible for administering the Medicaid program in Texas. Stip. 9.

9. At all times pertinent to this action, the National Heritage Insurance Company (NHIC) was the designated Medicaid Carrier responsible for processing and reimbursing claims submitted to the Texas Medicaid program. Stip. 10.

10. The Inspector General (I.G.), in a Notice letter of September 15, 1989 (Notice), alleged that Respondents presented or caused to be presented to Blue Cross: (1) 37 Medicare claims for services that they knew, had reason to know, or should have known were not provided as claimed, and (2) 172 Medicare claims for services furnished during a period when they were excluded from participation in the Medicare program.

11. The I.G. also alleged that Respondents had presented or caused to be presented to NHIC 51 claims for Medicaid items and services that they knew, had reason to know, or should have known were not provided as claimed.

12. The I.G. also alleged that Respondents presented or caused to be presented 88 claims to Medicare and Medicaid that fraudulently misrepresented the amount of time spent by Respondents or by certified registered nurse anesthetists (CRNAs) in rendering services to Medicare

and Medicaid patients in violation of section 1128A(a)(1)(A).

13. The 88 claims were claims for anesthesia services that were provided between November 1, 1983, and November 29, 1984. I.G. Ex. 1-1-88-1, 1-2-88-2.

14. The I.G. also alleged that Respondents submitted 172 unassigned claims for reimbursement for anesthesia services between September 1, 1987 and June 9, 1988 while Respondent Keszler was suspended or excluded from participation based on a conviction for conduct relating to one of the false Medicaid claims (claim 39) at issue in this case.

15. The I.G. appended an attachment to his Notice which indexed the allegedly false claims at issue in this case as counts 1-260.

16. Respondents admitted that they presented for Medicare or Medicaid reimbursement the 88 claims described in counts 1-88. Stip. 13, 14.

17. Respondents presented or caused to be presented for Medicare reimbursement the 172 claims described in counts 89-260. I.G. Ex. 89-1-260-1.

18. Respondent Keszler became a member of the staff at Memorial Medical Center in 1982 and served as head of the anesthesia department from 1982-1986. Tr. at 361-362, 388-389, 422, 727-729, 738.

19. Respondent Keszler determined the medical and billing policies and practices of the anesthesia department while serving as its head. Tr. at 161, 365, 728.

20. Respondent Keszler first employed and later contracted with various CRNAs from 1982 until August of 1986, including Tim Turney, Carolyn Rouse, Jerry Lazerus, Roland Daigle and Rusty McMinn. Tr. at 147, 549, 629, 838; I.G. Ex. 343, 345, 346.

21. The CRNAs administered anesthesia under Respondent Keszler's direction. Tr. at 147-150, 738-739.

22. Respondent Keszler directed four CRNAs concurrently during the years 1982-1986. Tr. at 148-150, 744, 759, 857, 921.

23. John Barrett, M.D., the only other anesthesiologist in the anesthesiology department between 1984 and 1986,

handled his own cases and did not direct CRNAs. Tr. at 149, 362, 929.

24. Anesthesia personnel at Memorial Medical Center prepared anesthesia records which documented the services they provided in each case. I.G. Ex. 1-2-88-2; Tr. at 152, 156, 165, 635.

25. In each case, the CRNA recorded in graphic form on the anesthesia record the anesthesia services provided, from the time that anesthesia was induced to the time the patient emerged from anesthesia. I.G. Ex. 1-2-88-2; Tr. at 168-173, 558-559, 635-636, 639, 643.

26. In each case, the CRNA also recorded in numeric form on the anesthesia record, the anesthesia start and end times, and the total time spent providing anesthesia. I.G. Ex. 1-2-88-2; Tr. at 167-168, 171-172, 559-560, 636, 639, 644.

27. At Memorial Medical Center, the time spent providing anesthesia in each case generally coincided with the time spent providing surgery in that case, as is evidenced by the CRNAs' graphs and the surgery beginning and end times on the anesthesia records. Tr. at 167-168; I.G. Ex. 1-2-88-2.

28. Induction and emergence from anesthesia at Lufkin Memorial usually occurred in the operating rooms, and not elsewhere. Tr. at 554-555, 630, 734-735.

29. After emergence, a patient was transported to post anesthesia recovery (PAR) by the person who had administered the anesthesia. Tr. at 153-154, 369-371, 555-556, 630-631.

30. When an anesthesiologist or a CRNA brought a patient to PAR, he or she would check the patient's vital signs and report potential medical problems to the recovery room nurse. Tr. at 154, 370-371, 556, 631, 741-742; I.G. Ex. 346.

31. When patients were brought into PAR, their postanesthetic condition, including complications, was recorded in the "postanesthetic condition" section of the anesthesia record. Tr. at 173-174, 637; I.G. Ex. 1-2, 7-2.

32. In the unusual case that it would have been necessary to provide more than routine post-anesthesia care upon arrival in the recovery room, that information would have been recorded in the "postanesthetic

condition" section of the anesthesia record. Tr. at 640-641; I.G. Ex. 4-2/2, 343, 345.

33. It was not common for anesthesia personnel to return to the recovery room to deal with a medical problem, once a patient was left in the care of recovery room personnel. Tr. at 181-182, 632, 943.

34. It was never necessary for anesthesia personnel to spend an hour in the recovery room providing care to a patient. Tr. at 182, 558.

35. Approximately 25% of the anesthesia patients at Memorial Medical Center between 1982-1986 were cataract patients who required either no services or only routine services in the recovery room. Tr. at 162-163, 178-179, 411-412, 638, 646-647; I.G. Ex. 2-1, 3-1, 5-1, 7-1, 21-1, 31-1.

36. In the anesthesia cases represented by the claims contained in counts 1-88, the actual time spent providing anesthesia is established by the graphic notations of anesthesia time contained in the anesthesia records generated by anesthesia personnel. Tr. at 169-170, 559, 635; I.G. Ex. 1-2-88-2.

37. In each of these 88 cases, there is a substantial discrepancy between the actual anesthesia time, as established by the graphic notations contained in the anesthesia record, and the amount of time claimed as anesthesia time in the reimbursement claim. I.G. Ex. 1-1-88-1, 1-2-88-2.

38. In nearly all of these 88 cases, there is a substantial discrepancy between the actual anesthesia time, as established by the graphic notations contained in the anesthesia record, and the total anesthesia time stated numerically in the anesthesia record. I.G. Ex. 1-2-88-2.

39. Pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), on March 2, 1983, new Medicare regulations were published which revised the standards governing Medicare's reimbursement of anesthesiologists. 42 C.F.R. 405.550 et seq; I.G. Ex. 325; Tr. at 275-276.

40. Effective with claims processed on or after October 1, 1983, for dates of service on or after July 1, 1983, reimbursement for anesthesiology services would no longer be based on historical profile data, but would be based on a point system. I.G. Ex. 325.

41. Medicaid adopted the same method as Medicare for implementing anesthesia services under the Texas Medicaid program, for dates of service on or after October 1, 1983, which claims were processed on or after January 6, 1984. I.G. Ex. 329, 326; Tr. at 219.

42. In order to determine a reasonable charge for anesthesia services, reimbursement under TEFRA's point system method is based on a combination of "base unit" points attributable to the type and complexity of the anesthesia procedure performed, and separate "time unit" points attributable to the duration of time spent performing an anesthesia procedure. 42 C.F.R. 405.552, 42 C.F.R. 405.553; Tr. at 49-51, 219, 275-276, 301-302.

43. Under TEFRA, reimbursement may be obtained for the period:

> beginning from the time the physician or anesthetist begins to prepare the patient for induction of anesthesia, and ending when the patient may be safely placed under post-operative supervision and the physician or anesthetist is no longer in personal attendance.

42 C.F.R. 405.553(b)(2).

44. Within the meaning of 42 C.F.R. 405.553(b)(2), "personal attendance" means that a physician is actively involved in providing anesthesia services to a patient, and it is only such provision of anesthesia services that is reimbursable under the "time" unit portion of TEFRA. See 42 Fed. Reg. 8928 (March 2, 1983).

45. Reimbursable anesthesia time under TEFRA usually approximates surgery time. Tr. at 118, 278-281, 305, 338-339; I.G. Ex. 324.

46. Reimbursable anesthesia time under TEFRA may exceed surgery time in those circumstances where anesthesia personnel actually provide anesthesia beyond completion of surgery. Tr. at 54-55, 56, 66-67, 115, 121, 338-340.

47. In calculating time unit reimbursement under TEFRA, the only post-operative time that usually should be considered is the minimal time it routinely takes following surgery for the patient to be safely placed "under post-operative supervision." 42 C.F.R. 405.553(b)(2); Tr. at 302-303; I.G. Ex. 325.

48. PAR time is normally not reimbursable anesthesia time under TEFRA. Tr at 56-59, 278.

49. PAR time, to the extent it involves anesthesia personnel, is deemed to be "indicated post-anesthesia care" under TEFRA, and is reimbursed as part of the base units. Tr. at 55-57, 118-119, 136-137, 275-281, 301-304; 42 C.F.R. 405.552(a)(1)(vii).

50. In the PAR records at Memorial Medical Center, recovery room nurses recorded events which took place in the recovery room on behalf of patients, i.e. administration of medication or any procedures performed on a patient. Tr. at 571-574, 614-615; I.G. Ex. 343.

51. Patient complications in the recovery room at Lufkin Memorial necessitating intervention by anesthesia personnel were rare. Tr. 565-568, 946; Tr. 177 and I.G. Ex. 1-2/3; Tr. 560-561 and I.G. Ex. 25-2; I.G. Ex. 3-2/3, 5-2/3, 7-2/3, 10-2/3, 11-2/3, 28-2/4, 31-2/4, 35-2/3, 42-2/3, 43-2/3, 44-2/3, 46-2/3, 47-2/3, 48-2/3, 53-2/2, 54-2/2, 58-2/3, 59-2/2, 63-2/2, 64-2/2, 67-2/2, 68-2/3, 70-2/3, 71-2/3, 72-2/3, 74-2/3, 75-2/3, 78-2/3, 79-2/4, 81-2/2; I.G. Ex. 343, 88-2, 8-2, 9-2, 30-2; I.G. Ex. 346, 20-2, 50-2, 45-2, 15-2.

52. In the cases contained in counts 1-88, PAR records do not document any post-surgical intervention by anesthesia personnel, with the exception of the cases contained in counts 24, 27, 32, 52, 84, and 86. I.G. Ex. 24-2/4, 27-2/4, 32-2/4, 52-2/4, 84-2/4, and 86-2/3.

53. In none of the cases where post-surgical intervention by anesthesia personnel is documented do the PAR records demonstrate more than brief intervention by anesthesia personnel. I.G. Ex. 24-2/4, 27-2/4, 32-2/4, 52-2/4, 84-2/4, and 86-2/3.

54. In none of the cases where post-surgical intervention by anesthesia personnel is documented, does the time spent performing such intervention account for the discrepancy between actual anesthesia time (as established by graphic notation in the anesthesia record), and the total anesthesia time stated on the record. I.G. Ex. 24-2/4, 27-2/4, 32-2/4, 52-2/4, 84-2/4, and 86-2/3.

55. Medicare's medical direction requirements are designed to prohibit an anesthesiologist from obtaining reimbursement under Part B if he provides services in the recovery room while supposedly directing CRNAs performing concurrent procedures. 48 Fed. Reg. 8928 (March 2, 1983).

56. To educate physicians about Medicare's new reimbursement policies under TEFRA, Blue Cross sponsored various Part B training workshops. I.G. Ex. 327.

57. Patsy Hines, Respondents' office manager, attended training workshops to learn about Medicare's new reimbursement policies under TEFRA. Tr. at 716, 767.

58. Blue Cross disseminated newsletters to inform providers of the changes in reimbursement under TEFRA. I.G. Ex. 325, 328.

59. Physician Newsletter 154, which outlined the procedures for anesthesiologists to follow to obtain reimbursement for anesthesia services under TEFRA, was promulgated by Blue Cross on September 30, 1983 for dissemination to Texas physicians, including Respondent Keszler. I.G. Ex. 325.

60. Respondents received Physician Newsletter 154. Stip. 20.

61. To make appropriate time unit reimbursement determinations consistent with TEFRA policy that reimbursable anesthesia time approximates surgical time, Blue Cross issued the requirement in Newsletter 154 that anesthesiologists disclose surgical procedure time on their claim forms. Tr. at 59, 278-279.

62. Respondents understood Newsletter 154 to permit them to bill, as anesthesia time, the time period "from the induction of anesthesia until the patient was released to the recovery room or out of the hospital." Tr. at 765.

63. Respondent Keszler reviewed Newsletter 154 and discussed it with Ms. Hines. Tr. at 694, 763-764.

64. Medicaid, which requires participation in Medicare as a condition to participation in Medicaid, changed its reimbursement methodology for anesthesia services to the same formula as was implemented by Medicare pursuant to TEFRA. I.G. Ex. 329; Tr. at 219, 222.

65. NHIC informed participating physicians about Medicaid's post-TEFRA anesthesia reimbursement changes in Bulletin Nos. 41 and 42, disseminated in December of 1983 and April of 1984, respectively. I.G. Ex. 329, 330; Tr. at 220-221.

66. Respondents received Bulletin Nos. 41 and 42. Stip. 20.

67. Subsequent to his learning of TEFRA reimbursement requirements, Respondent Keszler instructed the anesthesiology staff to add an extra hour to total anesthesia time on the anesthesia records for all Medicare and Medicaid patients, who could be identified by the hospital admission or "face" sheet in the record. Tr. at 549-550, 619-620, 636-637, 156-158, 364; I.G. Ex. 343, 345.

68. Respondent Keszler instructed the anesthesia staff to overstate total anesthesia time in Medicare and Medicaid cases in order to increase Respondents' reimbursement from Medicare and Medicaid. Tr. at 157, 434-436, 549-550; I.G. Ex. 343, 345.

69. Respondent Keszler reminded CRNAs who forgot to overstate total anesthesia time that it was necessary for them to do so. Tr. at 157, 565, 569, 639-640, I.G. Ex. 8-2/3, 11-2/1, 18-2/1, 22-2/1, 88-2/1, 343, 345.

70. Respondent Keszler interrupted CRNAs in the performance of their anesthesia duties to remind them to add time to anesthesia records in Medicare and Medicaid cases. Tr. at 564-565; I.G. Ex. 343, 345.

71. Respondent Keszler personally changed the total anesthesia time on anesthesia records which had been prepared by CRNAs. Tr. at 159-160, 424, 428, 433-437, 565, 810; I.G. Ex. 342, 345, 346.

72. Anesthesia times were changed on the anesthesia records in the cases stated in counts 9, 11, 12, 20, 22, 23, 26, 27, 28, 30, 31, 32, 33, 35, 40, 42, 55, 60, 62, 71, 73, 74, 75, 84, and 87. I.G. Ex. 9-2, 11-2, 12-2, 20-2, 22-2, 23-2, 26-2, 27-2, 28-2, 30-2, 31-2, 32-2, 33-2, 35-2 40-2, 42-2, 55-2, 60-2, 62-2, 71-2, 73-2, 74-2, 75-2, 84-2, 87-2.

73. Respondents' clerical staff used two medical records to prepare Respondents' Medicare and Medicaid claims: 1) the hospital admission sheet, also called a "face sheet", which identifies the patient's insurer and describes the surgical procedure performed, and 2) the anesthesia record, which provides the anesthesia time. Tr. at 470, 690-691, 701-702.

74. Physician order or "progress sheets" were never used to do billing. Tr. at 704.

75. Respondents directed their clerical staff to state on Medicare and Medicaid claims that anesthesia time was

the time recorded on anesthesia records as total anesthesia time. Tr. at 691, 701.

76. Blue Cross and NHIC, the Medicare and Medicaid carriers, improperly paid Respondent for this extra recovery room time in the 88 claims relating to counts 1-88. I.G. Ex. 1-3 through 88-3; Tr. at 59, 228.

77. The reimbursement claims stated in counts 1-88 falsely state reimbursable anesthesia time. Findings 36-38; I.G. Ex. 1-1-88-1, 1-2-88-2.

78. The false statements of reimbursable anesthesia time in the claims stated in counts 1-88 are the consequence of Respondents': (1) directive to anesthesia staff to overstate total anesthesia time on anesthesia records, and (2) directive to their clerical staff to state on claims that anesthesia time was the total anesthesia time recorded on anesthesia records. Findings 67-73, 75.

79. A person "knows" that an item or service is not provided as claimed within the meaning of the Act when he or she knowingly presents or causes to be presented false claims.

80. It is not necessary for a respondent to personally make a false claim in order to satisfy the "knows" test. A person "knows" a claim is false when he or she knows that the information that they are placing or causing to be placed on a claim form is false.

81. A person has "reason to know" that an item or service is not provided as claimed where he or she is a provider of items or services and: 1) the provider had sufficient information to place him, as a reasonable medical provider, on notice that the claims presented were for services not provided as claimed, or 2) there were pre-existing duties which would require a provider to verify the truth, accuracy and completeness of claims.

82. A person "should know" that an item or service is not provided as claimed, within the meaning of the Act, where: 1) that person has reason to know that items or services were not provided as claimed; or 2) is negligent in preparing and submitting, or in directing the preparing and submitting of, claims.

83. At all times relevant to this action, Respondents knew the standards governing Medicare and Medicaid's reimbursement of anesthesiologists under TEFRA. Respondents also knew that the amount of Medicare and Medicaid reimbursement they received would depend in part

on the amount of anesthesia time which they claimed. Findings 56-68; Tr. at 763-765.

84. Respondents knew that they could not routinely claim Medicare reimbursement pursuant to TEFRA for PAR time, regardless whether Respondent Keszler or CRNAs working under his direction provided "indicated postanesthesia care" to patients in PAR. Findings 62-64, 66-68.

85. Respondents knew that neither Respondent Keszler nor CRNAs working under his direction provided care in PAR, with the exception of the care documented for the claims contained in counts 24, 27, 32, 52, 84, and 86. Findings 30-34, 36-38, 52-54, 67-72.

86. Respondents knew that the anesthesia records on which the claims contained in counts 1-88 were based falsely stated the total anesthesia time in each case. Findings 36-38, 67-72.

87. Respondents knew that they had falsified the anesthesia time stated in the claims contained in counts 1-88, in order to increase their reimbursement from Medicare. Findings 67, 68.

88. Respondents knew that the services stated in the claims contained in counts 1-88 were not provided as claimed. Findings 52-54, 67-72.

89. Respondents knew that the services stated in the claims contained in counts 1-88 were false or fraudulent. Findings 52-54, 67-72.

90. As reasonable medical providers, Respondents were under a duty to assure that the claims contained in counts 1-88 did not contain false statements of anesthesia time, because Respondents knew that the anesthesia records for the claims contained in counts 1-88 contained false information, and knew that their clerical staff would rely on these records to prepare Medicare and Medicaid claims. Findings 52-54, 67-73, 75.

91. Respondents did nothing to prevent false statements from being made in the claims contained in counts 1-88. Findings 73, 75.

92. Respondents had reason to know that the services stated in the claims contained in counts 1-88 were not provided as claimed. Findings 52-54, 67-73, 75.

93. Because Respondents had reason to know that the items or services stated in the claims contained in

counts 1-88 were not provided as claimed, Respondents should have known that the items or services stated in these claims were not provided as claimed. Findings 52-54, 67-73, 75.

94. At the least, Respondents were indifferent to whether the items or services stated in the claims contained in counts 1-88 were provided as claimed. Findings 52-54, 67-73, 75.

95. On March 11, 1987, Respondent Keszler pleaded guilty to the Texas felony offense of Tampering With a Governmental Record, a violation of V.T.C.A., Texas Penal Code, Section 37.10(a)(2). (i.e., a Texas Medicaid claim form.) Stip. 22; I.G. Exs. 331, 332; R. Ex. 17, 22.

96. The criminal charges against Respondent Keszler and his conviction were the result of an investigation into his anesthesia claims for Medicare and Medicaid. R. Ex. 17; Tr. at 771-773, 777-778.

97. In pleading guilty, Respondent Keszler admitted that he fraudulently overstated anesthesia time in a Medicaid claim. R. Ex. 16, 17.

98. On March 11, 1987, in the District Court of Angelina County, Texas, Respondent Keszler was convicted of a criminal offense related to the Medicaid program. R. Ex. 16, 17.

99. Respondent Keszler's conviction related to the claim described in count 39 of the I.G.'s Notice.

100. On January 12, 1990, I entered summary disposition against Respondents on count 39, based on the principle of collateral estoppel, in which I found that Respondents presented or caused to be presented the claim contained in count 39 in violation of section 1128A(a)(1)(A) and (B) of the Act.

101. As part of his sentence, Respondent Keszler was ordered to make restitution to the Medicare and Medicaid programs in the amount of $37,500. R. Ex. 22.

102. Respondent Keszler agreed as part of his plea bargain to withdraw from participation as a participating physician in the Medicare and Medicaid programs for a period of two and a half years. R. Ex. 17.

103. Respondent Keszler plea agreement specifically did not release Respondent from any civil liability. R. Ex. 17.

104. On July 13, 1987, the I.G. notified Respondent Keszler of his determination to suspend Respondent Keszler from participation in the Medicare program for a period of five years, effective July 28, 1987, and to direct Medicaid to suspend Respondent Keszler from the Medicaid program for the same period of time, pursuant to section 1128(a) of the Act and 42 C.F.R. 1001.100 et seq. I.G. Ex. 331.

105. Respondent Keszler was also notified that if he continued to submit claims during the term of his suspension, he could be liable under the Act. I.G. Ex. 331.

106. The effect of the suspension was that Medicare and Medicaid would not pay for services furnished by or at the direction of Respondents. I.G. Ex. 331, 336; Tr. at 121.

107. Respondents were barred by the suspension from indirectly obtaining reimbursement from Medicare or Medicaid for Medicare or Medicaid services, by inducing beneficiaries or recipients to claim Medicare reimbursement for services or medical direction furnished by Respondent Keszler. 42 CFR 1001.126; section 1128(a)(1) of the Act, Tr. at 76-80.

108. Subsequent to Respondent Keszler's suspension, Respondents induced Medicare beneficiaries to seek reimbursement from Medicare for services provided by Respondent Keszler, or at his direction, and to remit that reimbursement to Respondents. I.G. Ex. 335; Tr. at 697-700, 800-804.

109. At Respondent Keszler's direction, Ms. Hines prepared and submitted to Medicare unassigned claims for services furnished while Respondent Keszler was suspended from Medicare. Tr. at 697-700, 800-804; I.G. Ex. 89-1-312-1.

110. Ms. Hines prepared a letter which she showed to Respondent Keszler, and which she sent to each of Respondents' Medicare patients. I.G. Ex. 335.

111. Respondent Keszler personally reviewed and approved the letter. Tr. at 720; I.G. Ex. 335.

112. The letter instructed the Medicare beneficiary to sign an enclosed Medicare reimbursement claim. I.G. Ex. 335.

113. The letter stated that Respondents' billing office would then submit the claim to Medicare. I.G. Ex. 335.

114. The letter requested the beneficiary to endorse any Medicare reimbursement checks, when received, to Respondents. I.G. Ex. 335.

115. The letter added that if the beneficiary immediately endorsed the Medicare reimbursement check over to Respondents, Respondents would give the beneficiary a discount on any unpaid balance of Respondents' bill and would also file other insurance claims on behalf of the beneficiary. I.G. Ex. 335.

116. Medicare will pay the first claim for services of an excluded or suspended provider submitted by a beneficiary, and then immediately give the beneficiary notice of the exclusion or suspension, because Medicare does not want a beneficiary to be harmed by the fact that he or she may be unaware that a provider has been excluded or suspended. 42 C.F.R. 1001.126(d); Tr. at 79-80, 83-85, 531.

117. Typically, a service provided by an anesthesiologist to a patient is the first service which that anesthesiologist provides to that patient, because anesthesia is linked to surgery, which generally does not involve multiple encounters. Tr. at 382-385, 967.

118. Many of the 172 Medicare claims which Respondents induced patients to sign, and which Respondents presented subsequent to their suspension, constituted the first post-suspension reimbursement claims for anesthesia services provided to those patients. See I.G. Ex. 89-1-260-1.

119. Respondents' billing office submitted claim forms marked "unassigned" and signed by patients to Medicare. These claim forms appeared to be submitted by beneficiaries. Blue Cross was induced to pay these claims, consistent with Medicare's policy of reimbursing a beneficiary's first claim for services of a suspended or excluded physician. Finding 116; I.G. Ex. 89-1-260-1, 89-2-260-2; Tr. at 78-79; I.G. Ex. 351.

120. After Respondent Keszler was suspended from participation in Medicare and Medicaid, Respondents presented or caused to be presented 172 unassigned Medicare claims, representing services furnished by Respondent Keszler or CRNAs under his direction, in violation of section 1128A(a)(1)(D) of the Act. I.G. Ex. 89-1-260-1.

121. Subsequent to their suspension, Respondents induced Medicare beneficiaries to sign most of the claims for Medicare benefits contained in counts 89 through 260. See I.G. Ex. 89-1-260-1.

122. Pursuant to Respondents' directions beneficiaries who were patients of Respondents returned to Respondents the claims contained in counts 89 through 132, and 134 through 260, and Respondents presented these claims to Medicare for reimbursement. I.G. Ex. 89-1-132-1, 134-1-260-1.

123. The claim contained in count 133 was presented directly to Medicare by a beneficiary who was a patient of Respondents. I.G. Ex. 133-1.

124. Respondents were able to obtain reimbursement for the services claimed in counts 89 through 260 by inducing their patients to present claims and to remit any Medicare reimbursement to Respondents. Findings 108-115.

125. Under section 1128A(a)(1)(D), Respondents are strictly liable for submitting or causing to be submitted the 172 Medicare claims for services furnished by them during their suspension. Findings 108-115, 119.

126. Respondents presented or caused to be presented the Medicare claims contained in counts 89 through 260 during a period when they were suspended from participating in Medicare and Medicaid, in violation of section 1128A(a)(1)(D) of the Act. Findings 104-115, 119.

127. Respondents had information which put them on notice that causing the 172 claims contained in counts 89-260 to be presented would violate section 1128A(a)(1)(D) of the Act. Findings 104-105.

128. Respondents did not prove that they were misled by government officials into believing that they could induce patients to present Medicare claims for Respondents' services during Respondent Keszler's suspension and have the patients remit Medicare reimbursement to Respondents.

129. Respondents did not prove that they believed in good faith that Medicare reimbursement regulations or the Act permitted them to induce patients to present Medicare claims for Respondents' services during Respondent Keszler's suspension and have the patients remit Medicare reimbursement to Respondents.

130. Respondents did not prove that they believed in good faith that they could withdraw as participating providers from Medicare and continue to receive Medicare reimbursement, notwithstanding Respondent Keszler's suspension.

131. The Act provides for the imposition of an assessment in lieu of damages of not more than twice the amount of each item or service which is falsely claimed. Social Security Act, section 1128A(a).

132. The Act provides for the imposition of a penalty of up to $2,000 for each item or service which is falsely claimed. Social Security Act, section 1128A(a).

133. The Act provides for the imposition of exclusions against parties found to have violated the Act, in order to protect the integrity of federally-funded health care programs. Social Security Act, section 1128A(a).

134. In determining the appropriate amount of assessments and penalties to be imposed against Respondents, the Act and regulations direct that both aggravating and mitigating factors be considered. Social Security Act, Section 1128A; 42 C.F.R. 1003.106.

135. If there are substantial or several aggravating circumstances, the aggregate amount of penalties and the assessment should be set at an amount sufficiently close to or at, the maximum permitted by law. 42 C.F.R. 1003.106(c).

136. In proceedings brought pursuant to the Act, a Respondent has the burden of proving the existence of any mitigating factors. 42 C.F.R. 1003.114(d).

137. The unlawful claims in this case were presented over a lengthy period of time, from November 2, 1983 through June 9, 1988. I.G. Ex. 27-1, 260-1.

138. The 260 claims which Respondents unlawfully presented or caused to be presented are a substantial number of unlawful claims. 42 C.F.R. 1003.106(b)(1).

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139. For the 260 claims at issue, Respondents falsely claimed a substantial amount of money, over $90,000. 42 CFR 1003.106(b)(1); I.G. Ex. 1-1-260-1.

140. On the basis of the false claims contained in counts one through 88, Medicare and Medicaid reimbursed Respondents more than $4,000. 42 CFR 1003.106(b)(1); I.G. Ex. 1-3-88-3,; Tr. at 505.

141. On the basis of the false claims contained in counts 89 through 260, Medicare reimbursed Respondents more than $25,000.00. 42 CFR 1003.106(b)(1); I.G. Ex. 89-2-260-2; Tr. at 506.

142. Given the resources allotted to the billing activity at Medicare, Medicare cannot independently verify the amount of time billed on every anesthesia claim, due to the volume of claims received. In 1983 Blue Cross received approximately 70,000 Medicare claims a day, and currently it receives 100,000 claims a day. Tr. at 273-274.

143. Medicare and Medicaid rely on the trustworthiness of participating anesthesiologists to state their anesthesia times truthfully when they certify that their claim forms contain no misrepresentations. Tr. at 70-71, 229, 232-234; I.G. Ex. 349.

144. Respondents' actions seriously damaged the reputation for probity and the integrity of the Medicare and Medicaid programs.

145. Penalties totalling $150,000.00 and assessments of $100,000.00 are appropriate in this case. Findings 137-141.

146. Respondents did not prove that the imposition against them of penalties totalling $150,000.00, and assessments of $100,000.00, jointly and severally, would jeopardize Respondents' ability to continue as health care providers. 42 CFR 1003.106(b)(4); R. Ex. 75, 76, 77; Tr. at 829-843, 888-895, 901-902.

147. Exclusions of Respondents from participating in Medicare and Medicaid for ten years are necessary to protect the integrity of federally funded health care programs. Social Security Act, section 1128A; Findings 137-141.

ANALYSIS

1. Respondents presented or caused to be presented claims for items or services in violation of section 1128A of the Act.

This case involves 260 Medicare or Medicaid claims for anesthesia services. Of these, 88 claims are claims for anesthesia services provided by or at the direction of Respondent Keszler which the I.G. alleges were not provided as claimed or were false or fraudulent, in violation of sections 1128A(a)(1)(A) and (B) of the Act. The remaining 172 claims are claims for anesthesia services provided by or at the direction of Respondent Keszler which the I.G. alleges were furnished during a period when Respondent Keszler was suspended from participating in the Medicare and Medicaid programs. The I.G. alleges that Respondents presented or caused to be presented these 172 claims in violation of section 1128A(a)(1)(D) of the Act.

Respondent Keszler is an anesthesiologist. Respondent Keszler, P.A., is a professional association which is solely owned and operated by Respondent Keszler. All of the claims at issue are for anesthesia provided by Respondent Keszler or at his direction during surgery at Memorial Medical Center in Lufkin, Texas. For all of the dates in question, Respondent Keszler was on the staff of Memorial Medical Center. During the period of time covered by the first 88 claims, Respondent Keszler served as the chief of the anesthesiology department at Memorial Medical Center.

The 260 claims at issue are claims for services which were allegedly provided by Respondents or by certified registered nurse anesthetists employed by Respondents between November 1983 and June 1988. The first 88 claims are for services which Respondents are alleged to have provided between November 1983 and November 1984. The remaining 172 claims are for services which Respondents are alleged to have provided between September 1987 and June 1988.

a. Violation of sections 1128A(a)(1)(A) and (B).

Section 1128A(a)(1)(A) of the Act makes it unlawful for a party to present or cause to be presented claims for items or services where that party knows or should know

that the items or services were not provided as claimed.[4] Section 1128A(a)(1)(B) makes it unlawful for a party to present or cause to be presented claims for items or services where that party knows or should know the claim is false or fraudulent.[5] The evidence in this case establishes that Respondents presented or caused to be presented the first group of 88 claims in violation of sections 1128A(a)(1)(A) and (B).[6]

There is no dispute that Respondents either presented or caused these 88 claims to be presented. The claims were actually presented for reimbursement by Respondent Keszler, P.A. However, Respondent Keszler owned and controlled Respondent Keszler, P.A., and its every action was at his direction. Findings 1-3.

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[4] Prior to December 22, 1987, this section's standard of liability for a party who filed a false claim was couched in terms of whether the party knew or had reason to know the item or service was not provided as claimed. On December 22, 1987, Congress retroactively substituted the "should know" standard for the "reason to know" standard. No court has decided the validity of Congress' retroactive application of the "should know" standard to claims for items or services presented prior to December 22, 1987. In light of this unresolved issue, I use the "knows" and "should know" standard of the 1987 revision, as well as the pre-revision "has reason to know" standard, to decide Respondents' liability under section 1128A(a)(1)(A).

[5] This section was added effective December 22, 1987, and is inapplicable to administrative actions commenced prior to that date. The administrative action in this case commenced after December 22, 1987. Unlike section 1128A(a)(1)(A), there is no previous version of this section which uses the "reason to know" standard to measure culpability requisite to establish a violation. Therefore, under section 1128A(a)(1)(B), a party is liable if he "knows" or "should know" that an item or service was not provided as claimed.

[6] On January 12, 1990, I entered summary disposition in favor of the I.G. with respect to one of this first group of 88 claims (count 39). My Ruling was based on principles of collateral estoppel and 42 C.F.R. 1003.114(c). The evidence which I received at the hearing in this case independently establishes the claim contained in count 39 to be false and to have been presented by Respondents in violation of sections 1128A(a)(1)(A) and (B).

The evidence establishes that the first 88 claims contain false statements of the amount of time spent by Respondent Keszler or by his CRNA employees providing anesthesia. These claims were generated by Respondents from anesthesia records which falsely state the time spent providing anesthesia. The anesthesia records were created by Respondent Keszler or by his CRNA employees and were used by Respondents' office staff as the basis for Medicare and Medicaid reimbursement claims. Findings 16, 19-22, 24-38, 62-73, 75.

Respondent Keszler determined that the reimbursement formula utilized by Medicare and Medicaid to compensate for anesthesia services reimbursed him inadequately. Therefore, he ordered his CRNA employees to overstate anesthesia time in anesthesia records, generally by one hour per procedure, in order to increase his reimbursement. Findings 67-72.

Prior to 1983, Medicare and Medicaid reimbursed anesthesiologists for their services based on anesthesiologists' charges for these services. The time anesthesiologists spent providing services was not an element of the reimbursement formula. However, this changed with the enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97-248, and the issuance of implementing regulations. 42 C.F.R. 405.550 et seq. These regulations mandated that, for Medicare, reimbursement for anesthesia services be established from a formula which included reimbursement for a base unit (a payment determined from the type of anesthesia service provided which reflected the complexity and difficulty of the service) and for the time actually spent providing anesthesia. 48 Fed. Reg. 8929 (March 2, 1983). The regulations permitted anesthesiologists to charge for time spent providing anesthesia:

> beginning from the time the physician or anesthetist begins to prepare the patient for induction of anesthesia, and ending when the patient may be safely placed under post-operative supervision and the physician or anesthetist is no longer in personal attendance.

42 C.F.R. 405.553(b)(2).

Medicare assured that the substance of these regulations was disseminated to anesthesiologists and their office staffs, and Respondents received publications advising them of the reimbursement changes. Findings 58-60. The

Texas Medicaid program adopted the same reimbursement formula as was contained in the new regulations, and notified health care providers, including Respondents, of this change. Findings 64-66.

Respondent Keszler instructed his employees to overstate the amount of time spent providing anesthesia in order to evade the reimbursement limitations established by the regulations. His purpose is underscored by the fact that he limited the directive that anesthesia time be overstated only to Medicare and Medicaid cases. He told his employees that overstating anesthesia time in such cases was necessary, because he had to do something to bring his Medicare reimbursement up to the reimbursement level that he received in private cases, and overstating anesthesia time was a means of doing so. Tr. at 438. Respondent Keszler told his staff to "f--- them b-------" (expletive deleted) at Medicare and Medicaid. Tr. at 156.

Respondent Keszler denies instructing his employees to overstate anesthesia time. He argues that the anesthesia time recorded in anesthesia records was intended to capture the time patients spent in post-anesthesia recovery ("PAR"), which he assumed, in good faith, that he was entitled to claim as part of the reimbursable time units for anesthesia services. Respondents assert that either Respondent Keszler or CRNAs personally attended patients throughout their stays in PAR.[7] They claim, therefore, that under their good faith interpretation of the regulations, they honestly believed that they were entitled to claim reimbursement for that time as anesthesia services.

Respondent Keszler's claim that he did not instruct CRNAs to overstate anesthesia time is not credible. His testimony is belied by the credible testimony of CRNAs who were employed by Respondents and who executed Respondent Keszler's instructions to overstate anesthesia time. Respondent Keszler's assertion that he relied in good faith on regulatory language which he interpreted as permitting him to claim reimbursement for PAR time defies the plain meaning of the regulation or the explanatory documents which he received from Medicare. Moreover, the evidence fails to support Respondents' contention that

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[7] Even if Respondent Keszler or a CRNA spent time helping out in PAR, Respondents would be reimbursed under TEFRA only for <u>anesthesia</u> services rendered. Respondents would not be reimbursed for assisting recovery room personnel with recovery room care.

Respondent Keszler or CRNAs personally attended patients while they were in PAR. Therefore, Respondents had no basis to claim reimbursement for PAR time even under their "interpretation" of Medicare reimbursement criteria.

The I.G. produced as witnesses several CRNAs who had been employed by Respondents. They credibly testified that Respondent Keszler instructed them to add one hour of anesthesia time to each procedure, as a means of increasing Medicare and Medicaid reimbursement. They testified that, when they failed to execute this instruction, Respondent Keszler would direct them to "correct" anesthesia records to reflect the added time. The testimony of each CRNA was reinforced by its consistency with that of the other CRNAs.

The testimony was also reinforced by its consistency with the anesthesia records generated in the cases that resulted in the 88 claims. Not only do these records corroborate the testimony of the CRNAs as to the instructions they received from Respondent Keszler, they establish that anesthesia time was overstated in each of the 88 claims. These records show that anesthesia time was entered by the person who provided anesthesia both in graphic form and as a numeric total. In nearly all cases, the graphs show anesthesia time roughly equivalent to the amount of time spent on the case by the surgeon. The graphs record the moment that induction of anesthesia occurred and the moment that the patient was brought out of anesthesia and sent to PAR. They also record the various interim procedures rendered by the person providing anesthesia. The graphs accurately record the time spent on a particular case by the person who provided anesthesia. By contrast, the numeric statement of anesthesia time in all 88 cases overstates the amount of time spent providing anesthesia, generally by one hour.[8] It is also evident from these records that, in many cases, the total anesthesia time stated on the

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[8] It is apparent from analysis of the exhibits that the instruction was simply to add time and not to assure that anesthesia time included the actual time patients spent in PAR. Many of the records for the 88 claims record total anesthesia time which is less than or greater than the time for anesthesia plus the time the patients spent in PAR. See, e.g., I.G. Ex. 67-2. In that case, the administration of anesthesia ended at 2:10 p.m. The patient was discharged from PAR at 2:40 p.m. However, the anesthesia record states that anesthesia ended at 3:10 p.m.

record was altered to increase the total time stated by one hour. Finding 72.

Respondents argue that the CRNA witnesses were biased. There is evidence in the record to show that these individuals displayed animus towards Respondents. Nevertheless, I find the testimony of the CRNAs to be credible, because it is plausible, consistent with that given by other witnesses, and consistent with the records which these individuals generated.

Respondents assert that they interpreted the regulatory phrase "ending when the patient may be safely placed under post-operative supervision and the physician or anesthetist is no longer in personal attendance" to permit anesthesia claims to incorporate PAR time as an element of the time units claimed, provided that anesthesia personnel attended to patients while they were in PAR.

This is not a reasonable interpretation of the reimbursement criteria. The testimony of several witnesses, including personnel who were responsible for providing PAR services at Memorial Medical Center, was that in nearly all cases PAR constituted a holding process to monitor patients' vital signs until patients could be returned to their hospital beds (or in outpatient surgeries such as cataract operations, discharged from the hospital). PAR is non-reimbursable "post-operative supervision" as is described in the relevant Medicare reimbursement regulations and is not part of the anesthesia process. I conclude that no reasonable person who is familiar with the distinctions between providing anesthesia and PAR could be confused by this regulatory language. Respondents' assertions that they were confused or misled are therefore not credible.[9]

This is not to suggest that an anesthesiologist might not be required to intervene in PAR, and that the regulations would deny the anesthesiologist reimbursement for that intervention. The regulations contemplate emergency situations or circumstances where emergence from anesthesia might occur while the patient is physically

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The I.G. also offered evidence consisting of the testimony of the executive vice president and chief executive officer of Blue Cross and Blue Shield of Texas, the Texas Medicare carrier, that there was no confusion among the many anesthesiologists in Texas as to the meaning of the regulation.

removed from the operating room. The regulations enable anesthesiologists to be reimbursed in such circumstances. However, reimbursable post-surgery intervention is documented in only a few of the 88 claims. The medical records generated in those few cases document only brief intervention in PAR by anesthesia personnel, and not the extensive time beyond actual anesthesia time claimed by Respondents. Findings 52-54.

I do not conclude that Medicare regulations require anesthesia time to be coextensive with surgery in order to be reimbursable. Induction of anesthesia may begin prior to surgery. Emergence from anesthesia may occur after surgery is concluded. In both circumstances, the time spent on the case by the anesthesiologist or by a medically directed CRNA is reimbursable. However, that does not give an anesthesiologist carte blanche to routinely add time to his actual services in order to increase his Medicare or Medicaid reimbursement. In each of the 88 cases, the anesthesia record was falsified by adding time to the time spent actually providing anesthesia. The inevitable consequence in each case was a false reimbursement claim.

Respondents also argue that the regulation could be read to permit reimbursement for time spent by an anesthesiologist or a CRNA attending a patient in PAR, regardless of whether that time relates to the provision of anesthesia. I disagree that the regulations permit anesthesiologists to be reimbursed for routine monitoring in PAR. However, there is no proof that Respondents or their staff actually attended patients in PAR as Respondents now claim to have occurred. For the most part, the records do not document the presence of anesthesiologists or CRNAs in PAR. Respondents' former employees testified that their involvement in PAR was minimal. I do not find credible the testimony of one witness that Respondent Keszler mostly attended patients in PAR. The testimony was inconsistent with the weight of the evidence in this case.[10]

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[10] Respondents argue that the records in evidence do not completely document the PAR activities of Respondent Keszler and CRNAs. They suggest that there may exist other records, not in evidence, which would show much greater involvement in PAR by Respondent Keszler and CRNAs than is depicted by the exhibits that are in evidence. Respondents had the opportunity to obtain and offer in evidence such records as they thought were relevant. They did not produce any of the records which they suggest support their contentions.

Finally, Respondents' explanation for the 88 claims is belied by the fact that Respondent Keszler effectively admitted his fraud by pleading guilty in 1987 to a Texas state criminal charge of tampering with a government record. Respondent Keszler was charged with defrauding the Texas Medicaid program, by filing a Medicaid claim (count 39 in this case) which falsely stated anesthesia time. As part of a plea agreement, Respondent Keszler explicitly admitted to the elements of the offense. Although the claim contained in count 39 is but one of 88 claims at issue here, it is apparent that Respondent Keszler's fraudulent presentation of that claim is part and parcel of the fraud Respondents committed with respect to the remaining 87 claims.

Respondents knew that the items claimed in the first 88 claims were not provided as claimed and were false and fraudulent. A party "knows" that an item or service is not provided as claimed or is false or fraudulent when he or she knows that the information that he or she is placing or causing to be placed on a claim is untrue. Edward J. Petrus, Jr., M.D., and The Eye Center of Austin, DAB Civ. Rem. C-147 (1990); Tommy G. Frazier and Prater Drugs, DAB Civ. Rem. C-127 (1990); Anesthesiologists Affiliated et al. and James E. Sykes, D.O. et al., DAB Civ. Rem. C-99, C-100 (1990); Thuong Vo, M.D. and Nga Thieu Du, DAB Civ. Rem. C-45 (1989). It is not necessary for a respondent to personally make a false claim in order to satisfy the "knows" test. All that is necessary to satisfy the test is that a respondent issue instructions concerning the preparation of claims which he or she knows will result in the inclusion of false information in the claims.

Here, the evidence establishes that Respondent Keszler instructed CRNAs to make false statements in documents which Respondents knew would be used to prepare Medicare and Medicaid claims for anesthesia services. The necessary consequence of these instructions was that false claims would be presented based on these false statements of anesthesia time. Respondents knew that Respondent Keszler's instructions were implemented by Respondents' employees. The evidence establishes that Respondent Keszler personally reviewed anesthesia records to assure that his directives as to anesthesia time were being implemented. Respondent Keszler also signed many of the 88 claims.

Although I have concluded that Respondents knew that the items or services in the 88 claims were not provided as claimed or were false or fraudulent, the evidence also establishes, alternatively, that Respondents had reason

to know that the items or services in the 88 claims were not provided as claimed. The "reason to know" standard contained in section 1128A(a)(1)(A) prior to December 22, 1987, created a duty on the part of a provider to prevent the submission of false claims where: (1) the provider had sufficient information to place him, as a reasonable medical provider, on notice that the claims presented were for items or services not provided as claimed, or (2) there were pre-existing duties which would require a provider to verify the truth, accuracy, and completeness of claims. Petrus and The Eye Center of Austin, supra; Frazier and Prater Drugs, supra; Anesthesiologists Affiliated, supra; Vo, supra; George A. Kern, M.D., DAB Civ. Rem. C-25 (1987).

Assuming that Respondents did not know that the 88 claims were for items or services that were not provided as claimed, they were aware of information to place them, as reasonable medical providers, on notice that the claims presented were for items or services which were not provided as claimed. Respondents knew that Medicare defined anesthesia time in a manner which was palpably inconsistent with the way in which Respondents chose to define it. Assuming further that Respondents were confused as to the meaning of Medicare and Medicaid reimbursement criteria, they were under a duty to make reasonable inquiries to find out if their "interpretation" was correct. They did not do so.

Finally, the evidence establishes that Respondents should have known that the 88 items or services were not provided as claimed or were false or fraudulent. The broadest standard of liability under the Act is "should know." This standard subsumes reckless disregard for the consequences of a person's acts. It subsumes those situations where a respondent has reason to know that items or services are not provided as claimed or are false or fraudulent. "Should know" also subsumes negligence in preparing and submitting or in directing the preparing and submitting of claims or reckless disregard for the truth or falsity of claims. Mayers v. U.S. Dept. of Health and Human Services, 806 F.2d 995 (11th Cir. 1986), cert. denied, 484 U.S. 822 (1987); Petrus and The Eye Center of Austin, supra; Frazier and Prater Drugs, supra; Anesthesiologists Affiliated, supra; Vo, supra.

Inasmuch as the Respondents had reason to know that the items or services were not provided as claimed, they should have known that they were not provided as claimed, or that they were false or fraudulent. Furthermore, the evidence establishes that at the least, Respondents

displayed reckless indifference for whether relevant Medicare and Medicaid reimbursement criteria permitted them to claim PAR time as anesthesia time and for the truth of the claims which they presented.

b. Violation of section 1128A(a)(1)(D).

Section 1128A(a)(1)(D) of the Act makes it unlawful for a party to present or cause to be a presented a claim for a medical or other item or service during a period when the party was excluded (or, under previous versions of section 1128, suspended) from participation in Medicare or Medicaid.[11]

Congress intended that section 1128A(a)(1)(D) apply not only to reimbursement claims which are presented by excluded providers, but to those claims presented by Medicare beneficiaries and Medicaid recipients at the request of excluded providers. One purpose of section 1128A(a)(1)(D) is to prevent excluded providers from being reimbursed through the back door by beneficiaries and recipients, on a non-assigned basis. See S. Rep. No. 109, 100th Cong., 1st Sess. 3, reprinted in 1987 U.S. Code Cong. & Admin. News, 695.

On the other hand, it is neither Congress' nor the Secretary's purpose to penalize beneficiaries and recipients who obtain treatment from an excluded provider, not knowing that the provider has been excluded. That problem is addressed for Medicare beneficiaries by a regulation which provides that the first claim submitted by a beneficiary for services rendered by an excluded provider will be reimbursed. 42 C.F.R. 1001.126(d)(1). This regulation was not intended to redound to the advantage of excluded providers.

Unlike sections 1128A(a)(1)(A) and (B), section 1128A(a)(1)(D) does not require proof of culpability as an element of liability. The plain meaning of this section is to impose a strict liability standard. Petrus and the Eye Center of Austin, supra. The I.G. satisfies his burden under this section by proving that an excluded provider presents claims or causes claims to be presented during the period when he or she is excluded.

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[11] Prior to September 1, 1987, the law proscribed, at section 1128A(a)(1)(B), a party presenting or causing to be presented a claim for items or services, "payment for which may not be made under the program under which such claim was made." All of the 172 claims at issue here were presented after September 1, 1987.

The I.G. met that burden with respect to the 172 claims at issue here. As is noted supra, Respondent Keszler pleaded guilty in a Texas court to the state criminal offense of tampering with a government record. Based on this conviction, and pursuant to section 1128(a) of the Social Security Act, Respondent Keszler was suspended, effective July 28, 1987, from participating in Medicare and Medicaid. Respondents presented or caused to be presented all of the 172 claims subsequent to that date and during a period when Respondent Keszler was suspended from participation in Medicare and Medicaid. All of the 172 claims recite on their face that they are for services provided by Respondent Keszler or at his direction.

Respondents prepared the claim forms for 171 of the 172 claims and mailed them to the patients to whom they had provided services. Findings 122-123. They requested the patients to sign the claims and to return them to Respondents' office. Respondents then mailed the signed claims to Medicare and Medicaid. Respondents requested the patients to remit to Respondents any reimbursement checks that the patients received, based on the claims. Findings 108-115, 119-121, 124.

Although it is not necessary to find culpability as an element of a violation of section 1128A(a)(1)(D), I conclude that Respondents manifest a high degree of culpability with respect to the 172 claims. Respondents knew that they had been suspended from participating in Medicare and Medicaid. They knew that they would not be reimbursed by these programs during their suspension. I.G. Ex. 331. In light of that, it is evident that Respondents' plan to have patients submit claims and to remit reimbursement checks for those claims to Respondents was a scheme to evade the suspension.

Respondents assert that section 1128A(a)(1)(D) is inapplicable to the 172 claims. They note that the section refers to providers who have been "excluded" from participation in Medicare and Medicaid. They argue that an "exclusion" is not synonymous with a "suspension" and that, therefore, the section does not apply.

I disagree with this argument. It is evident from the language of section 1128A(a)(1)(D) and its history that the term "exclusion" as presently contained in the Act is synonymous with the term "suspension" in Section 1128(a) prior to September 1987. Therefore, section 1128A(a)(1)(D) applies both to excluded and suspended health care providers.

Respondents were suspended from participation in Medicare and Medicaid pursuant to the then-effective section 1128(a) of the Social Security Act. At the date of Respondents' suspension (July 1987), section 1128(a) mandated "suspension" of providers who were convicted of program-related crimes.

Congress revised section 1128 in August 1987. The revisions were intended to both broaden the reach of the section and to strengthen its provisions. Congress added language which expanded the scope of the mandatory exclusion provisions. Social Security Act, sections 1128(a)(1) and (2). For the first time, Congress adopted a minimum term of exclusion for mandatory exclusion cases. Social Security Act, section 1128(c)(3)(B). It adopted permissive exclusion provisions which gave the Secretary of the Department of Health and Human Services authority to impose exclusions in certain cases. Social Security Act, sections 1128(b)(1)-(14). In revising the law, Congress substituted the word "exclusion" for the word "suspension," which had been contained in previous versions of section 1128, including the version which immediately predated the 1987 revision. Congress simultaneously revised section 1128A, enacting the present section 1128A(a)(1)(D). Pub. L. 100-93, 101 Stat. 680 (1987). The revised section 1128A(a)(1)(D) was made parallel with the revised section 1128, applying to parties who had been excluded pursuant to section 1128.

The distinction now urged by Respondents rests solely on the semantic change made by Congress in 1987, rather than on any expression of Congressional intent or legislative history. There is nothing in this history which suggests that Congress intended to distinguish between suspended and excluded parties by its enactment of section 1128A(a)(1)(D). To the contrary, the revisions to section 1128 make it plain that Congress intended the words "suspension" and "exclusion" to be used interchangeably and to be synonymous, and that it intended its revision of section 1128A to be applicable both to suspended and excluded providers.

Respondents also argue that they were misled by 42 C.F.R. 1001.126(d)(1) into believing that they were entitled to encourage their patients to each submit for reimbursement one claim for services, and to have the patients remit reimbursement checks to Respondents. They base their argument on the language of the regulation. This regulation provides, in relevant part:

> **Denial of payment to beneficiaries.** If a beneficiary submits claims for items or

> services furnished by a suspended party . . . , on or after the effective date of the suspension --
>
> > (1) HCFA . . . [the Health Care Financing Administration] will pay the first claim submitted by the beneficiary and immediately give the beneficiary notice of the suspension.

As is noted above, the regulation was written to protect beneficiaries who might, without being aware that a provider had been excluded, obtain treatment from that provider. The regulation was plainly not intended to permit providers an avenue by which to circumvent exclusions.

That is evident from the context of the regulation. The regulation is a subsection of 42 C.F.R. 1001.126. This regulation unequivocally states in its other subsections that payment may not be made to a suspended provider for services furnished during a period of suspension. 42 C.F.R. 1001.126(a), (c).

Respondents' assertion that they in good faith interpreted the regulation to permit them to continue to receive reimbursement from patients for Medicare and Medicaid services is not credible, because no rational person would be persuaded by the absurd result of their reasoning. Rather, their asserted interpretation is a pretext for Respondents to continue to do what they should have known they were forbidden to do. If the regulation were read as Respondents assert, it would effectively render toothless most suspensions and exclusions. What purpose would exist in suspending or excluding a provider, if that provider could simply direct his or her patients to file claims for his services, and then demand reimbursement from those patients?

Respondents also argue that Respondent Keszler was led by his attorney to believe that his patients could each submit one claim for Medicare or Medicaid reimbursement for services provided by him after the date of his suspension, and could remit reimbursement checks to him. He produced his attorney as a witness. The attorney testified that, during a conversation that he was privy to, an agent of the I.G. stated Respondent Keszler's patients could be reimbursed for the first service

provided by Respondent Keszler for those patients subsequent to the date of his suspension.[12]

While I do not dispute the accuracy of this witness' recollection, it provides no basis for Respondents to conclude that they could continue to obtain Medicare and Medicaid reimbursement while suspended. The attorney's recollection of the agent's statement coincides with the language of 42 C.F.R. 1001.126(d)(1). That language, as I have noted, permits a patient of an excluded provider to be reimbursed for the first treatment the patient receives from such provider subsequent to the provider's suspension or exclusion. It does not permit, and cannot be legitimately read to permit, an excluded provider to continue to receive Medicare and Medicaid reimbursement for his or her services.

2. Assessments, penalties, and exclusions are appropriate in this case.

The remedial purpose of the Act is to protect government financed health care programs from fraud and abuse by providers. Mayers, supra, 806 F.2d at 997; Petrus and the Eye Center of Austin, supra at 43; Frazier and Prater Drugs, supra at 23; Anesthesiologists Affiliated, supra at 58; Vo, supra, at 22. The assessment and penalty provisions of the Act are designed to implement this remedial purpose in two ways. One is to enable the government to recoup the cost of bringing a respondent to justice and the financial loss to the government resulting from the false claims presented by that respondent. The other is to deter other providers from engaging in the false claims practices engaged in by a particular respondent. Mayers, supra, at 999; Frazier and Prater Drugs, supra, at 23; Anesthesiologists Affiliated, supra, at 58; Vo, supra, at 22.

The exclusion remedy is designed to protect the Medicare and Medicaid programs from future misconduct. Frazier and Prater Drugs, supra, at 23; Anesthesiologists Affiliated, supra, at 58. It is thus distinguishable from assessments, which compensate the government for wrongs already committed. Medicare and Medicaid programs have a contractual relationship with those providers who treat beneficiaries and recipients and present claims for reimbursement. Federally-funded health care programs are

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[12] The attorney who testified was an attorney other than the attorney who represented Respondents in this case.

no more obligated to continue to deal with dishonest or untrustworthy providers than any purchaser of goods or services would be obligated to deal with a dishonest or untrustworthy supplier. The exclusion remedy allows the Secretary to suspend his contractual relationship with those providers of items or services who are dishonest or untrustworthy. One purpose of any exclusion, therefore, is to exclude a provider for a sufficient period of time to assure that these programs will not continue to be harmed by dishonest or untrustworthy providers of items or services.

Exclusion serves an ancillary purpose of deterring providers of items or services, including those providers against whom the remedy is imposed, from engaging in the same or similar misconduct as that engaged in by the excluded providers. In that respect, it is an exemplary remedy because it reinforces the penalties which may be imposed pursuant to the Act. Frazier and Prater Drugs, supra, at 23; Anesthesiologists Affiliated, supra, at 58.

The Act and implementing regulations provide that a penalty of up to $2,000.00 and an assessment of not more than twice the amount claimed may be imposed on a respondent for each item or service which that respondent presents or causes to be presented in violation of the Act. Social Security Act, section 1128A(a); 42 C.F.R. 1003.103, 1003.104. The maximum penalties which I may impose against Respondents in this case are $520,000.00, based on their presenting 260 claims in violation of the Act. The maximum assessments which I may impose exceed $180,000.00, based on Respondents having claimed more than $90,000.00 on the 260 claims. The I.G. has requested that I impose penalties of $390,000.00 and assessments of $148,843.54.

Neither the law nor regulations provide for a maximum exclusion which I may impose. However, the regulations provide that the length of the exclusion should be determined by the same criteria that I employ to determine the appropriate amount of penalties and assessments. 42 C.F.R. 1003.107. In this case, the I.G. has requested that I exclude each Respondent for ten years.

Regulations provide that, in determining the amount of penalties and assessments, I may consider, as nonbinding guidelines, factors which may be either mitigating or aggravating. These include: (1) the nature of the claim or request for payment and the circumstances under which it was presented, (2) the degree of culpability of the person submitting the claim or request for payment, (3)

the history of prior offenses of the person submitting the claim or request for payment, (4) the financial condition of the person presenting the claim or request for payment, and (5) such other matters as justice may require. 42 C.F.R. 1003.106(a).

A respondent has the burden of proving the presence of mitigating factors, including financial hardship. 42 C.F.R. 1003.114(c). The regulations provide that, in cases where mitigating factors preponderate, the penalties and assessments should be set correspondingly below the maximum permitted by law. 42 C.F.R. 1003.106(c)(1). The regulations also provide that, in cases where aggravating factors preponderate, the penalties and assessments should be set close to the maximum permitted by law. 42 C.F.R. 1003.106(c)(2).

The Act has been interpreted to permit imposition of penalties and assessments which exceed the amount actually reimbursed to a respondent for items or services which were unlawfully claimed. Chapman v. U.S. Dept. of Health & Human Services, 821 F.2d 523 (10th Cir. 1987); Mayers, supra, 806 F.2d at 999. This reflects the legislative conclusion that activities in violation of the Act "result in damages in excess of the actual amount disbursed by the government to the fraudulent claimant."

I impose assessments of $100,000.00 and penalties of $150,000.00 against Respondents, jointly and severally, and I exclude them from participating in Medicare and Medicaid for ten years. The assessments and penalties will adequately compensate the government for the damages caused by Respondents. The penalties will, in conjunction with the exclusions that I am imposing, provide a reasonable deterrent. The exclusions will adequately serve to protect federally-funded health care programs from further fraud by Respondents and will operate as an additional deterrent.

a. Assessments.

There are several ways to measure the damages caused to the government by these Respondents. They unlawfully claimed more than $90,000.00 from Medicare and Medicaid. As a consequence of Respondents' unlawful claims, Medicare and Medicaid reimbursed approximately $30,000.00 to which Respondents were not entitled. Findings 139-141.

The government sustained additional costs by virtue of the investigation which was necessary to bring Respondents to justice. The I.G. produced the testimony

of an agent concerning the extensive efforts necessary to put together the evidence of Respondents' unlawful conduct. Thus, assessments of $100,000.00 will serve to recoup the pecuniary damages the government suffered as a result of Respondents' misconduct.

The damages caused to Medicare and Medicaid by Respondents' fraud exceeds any quantifiable pecuniary loss. Respondents' conduct damaged the integrity and the reputation for probity of the Medicare and Medicaid programs. Those damages cannot be quantified in dollars. The I.G. established that in Texas, alone, federally-funded health care programs receive more than 100,000 reimbursement claims per month. These programs are without the wherewithal to systematically audit claims. Providers of health care are essentially trusted to do the right thing when filing reimbursement claims. The programs, therefore, are open to the depredations of those who would commit wholesale fraud.

Respondents' fraud illustrates just how vulnerable these programs are. There was nothing complex or sophisticated about Respondents' scheme. Respondents' fraud was evident upon review of the relevant claims and treatment records. However, Respondents were able to perpetrate their scheme for a considerable period of time, because Medicare and Medicaid depended on Respondents to be honest.

Respondents' misconduct therefore raises serious questions about the integrity of Medicare and Medicaid, because its open and blatant nature suggests that even the most unsophisticated theft of program funds may go undetected. Such obvious, and for a time, successful fraud causes incalculable damages to the reputation of these programs. For this, the government deserves compensation.

b. Penalties.

The penalties of $150,000.00 which I impose against Respondents will, in conjunction with the assessments that I impose, serve to compensate the government for the damage caused by Respondents to the integrity of the Medicare and Medicaid programs. They will also serve to deter others from engaging in the fraud committed by Respondents.

The I.G. established the presence of many aggravating factors in this case. The 88 false claims presented by Respondents were presented in furtherance of a deliberate scheme to defraud Medicare and Medicaid. 42 C.F.R.

1003.106(b)(1). The 172 claims which Respondents caused to be presented after Respondent Keszler's suspension became effective were presented as part of a plan to circumvent and thwart that suspension. Id.[13] The claims in this case were presented over a lengthy period of time. Id. Respondents unlawfully claimed more than $90,000.00, a substantial sum. Id. Findings 137-141.

The I.G. also established a very high degree of culpability. Respondents knew that the 88 false claims were fraudulent. Respondents at least had reason to know that the 172 claims they presented or caused to be presented during the period of Respondent Keszler's suspension contravened the terms of the suspension and relevant laws. 42 C.F.R. 1003.106(b)(2). Furthermore, at the time Respondents presented or caused the 172 post-suspension claims to be presented, Respondent Keszler already had been found criminally liable for fraud against Medicaid. 42 C.F.R. 1003.106(b)(2). Findings 83-95, 126-127.

Respondents failed to prove the presence of mitigating factors. Respondents argued, by way of mitigation, that the claims at issue were the product of their misunderstanding or confusion about relevant regulations and reimbursement criteria. However, I have concluded that the regulations and criteria which Respondents claim to be ambiguous and confusing were, in fact, not ambiguous or confusing. Respondents' arguments are after-the-fact rationalizations designed to obfuscate willful misconduct.

Respondents attempted to prove that they were financially incapable of paying the penalties and assessments sought by the I.G. I am not persuaded by the evidence which Respondents offered. It was at best, incomplete and anecdotal. For example, Respondents introduced incomplete corporate tax returns for Respondent Keszler, P.A. These returns did not establish a complete financial picture of that Respondent. They shed no light on the financial circumstances of Respondent Keszler. Respondents did not introduce any of Respondent Keszler's personal tax returns, nor did they introduce any other of his personal financial records.

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[13] In addition to the 172 claims which Respondents caused to be presented, the I.G. has offered into evidence another 52 claims which Respondents caused to be presented after the effective date of Respondent Keszler's suspension. I.G. Ex. 261-1 - 312-1.

Respondent Keszler testified that he was without resources to pay penalties and assessments. I am not satisfied that his unsupported assertions of financial distress are credible, particularly in light of the fact that he offered no documentation to support his statements. Moreover, I found Respondent Keszler's testimony to be generally not credible. His lack of credibility on other issues impugns his testimony as to his financial resources.

My decision to impose penalties totalling $150,000.00 reflects, as I have stated, my conclusion as to the damages sustained by the government, and my finding that there exists a need to impose a credible deterrent in this case. It is justified by the presence of aggravating factors and the absence of mitigating factors. Indeed, were I to simply decide penalties based on the presence of aggravating factors and the absence of mitigating factors, I could easily justify penalties in an amount much greater than that which I have imposed.

However, the purpose of the Act is remedial and not punitive. The determination of penalties in particular cases must be based on the remedial considerations which I have identified, supra, and not just on those criteria which would normally be used to determine punishment. Penalties and assessments which are grossly disproportionate to the costs sustained by the government would render the Act punitive in its application. See United States v. Halper, 109 S. Ct. 1892 (1989); Petrus and the Eye Center of Austin, supra at 46-48.

My decision as to penalties and assessments in this case takes into consideration the evidence as to costs. The total which I have imposed -- $250,000.00 -- is not grossly disproportionate to the costs proven by the I.G. Therefore, the penalties and assessments serve the Act's purposes without becoming punitive in their application.[14]

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[14] My decision also takes into account that, as an aspect of his sentence on his plea of guilty to the criminal offense of tampering with a government record, Respondent Keszler was ordered to pay restitution totalling $37,500.00. The evidence in this case is that such restitution has not been paid. Tr. at 218-219, 839-840, 889-890. The penalties and assessments which I impose are not punitive when added to the amount which Respondent Keszler previously agreed to pay, because the total, including the restitution amount, is not grossly

(continued...)

c. Exclusions.

I exclude Respondents from participating in Medicare and Medicaid for ten years. Exclusions are necessary for two reasons. First, they will assure that Respondents will not be in a position to do further damage to the integrity of federally-funded health care programs. Second, they will warn health care providers that they cannot ignore their legal obligations to these programs.

My decision that ten-year exclusions are necessary in this case is in part based on the many aggravating factors which were proven, and the inescapable conclusion which must be drawn from those factors. The evidence in this case establishes that Respondents intentionally defrauded both Medicare and Medicaid. It also shows that Respondents had no interest in complying with program reimbursement criteria, if compliance interfered with their efforts to maximize their gain. Respondents are manifestly untrustworthy providers.

I also base the length of the exclusion on my conclusion that Respondents' fraud is the kind of misconduct for which Congress has prescribed a minimum mandatory exclusion of at least five years under section 1128(a) of the Social Security Act. In enacting that section, Congress' intent was not to prescribe additional punishment for parties convicted of program-related fraud. Rather, Congress concluded that parties who engage in theft, fraud, and other criminal offenses of a financial nature against Medicare or Medicaid have demonstrated by their conduct that they should not be trusted to do business with these programs for at least five years. See Jack W. Greene, DAB App. 1078 (1989) aff'd sub nom Greene v. Sullivan, 731 F. Supp. 835, 838 (E.D. Tenn. 1990). And, in enacting section 1128(a), Congress made it clear that exclusions of greater than five years should be imposed in appropriate cases.

I am not concluding that the evidence in this case as to the 87 claims other than count 39, or the 172 post-suspension claims, proves that Respondents committed a crime. However, I do conclude that Respondents have engaged in fraud within the plain and ordinary meaning of that term, and that in some respects it is appropriate to measure the reasonableness of the exclusions I am

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[14] (...continued)
disproportionate to the damages sustained by the government.

imposing by considering what Congress has mandated for cases of criminal fraud. Greene, supra.

Nor am I imposing a second, lengthier exclusion for the misconduct that resulted in Respondent Keszler's criminal conviction for fraud related to the claim in count 39. The suspension which was imposed based on count 39 related only to one Medicaid claim. Here, there exists massive evidence of a much wider-ranging fraud than was evident from that case. Furthermore, the record establishes continued misconduct by Respondents relative to the 172 post-suspension claims.

I recognize that the exclusions which I am imposing are likely to have a significant adverse financial effect on Respondents. However, the law places the integrity of the Medicare and Medicaid programs ahead of the pecuniary interests of providers. In determining to impose an exclusion, the primary consideration must be the degree to which the exclusion serves the law's remedial objectives. An exclusion is remedial if it does reasonably serve these objectives, even if it has a severe adverse impact on the person against whom it is imposed. Greene v. Sullivan, 731 F. Supp. 838, 840 (E.D. Tenn. 1990).

3. The penalties, assessments, and exclusions imposed in this case do not violate Respondents' rights not to be placed in double jeopardy.

Respondents argue that the imposition against them of penalties, assessments, and exclusions violates their rights not to be placed in double jeopardy. They premise their argument on Respondent Keszler's 1987 criminal conviction and the Supreme Court's decision in United States v. Halper, 109 S. Ct. 1892 (1989).

Respondents' arguments are in some respects the same as those made by respondents in Petrus and the Eye Center of Austin, supra. I found those arguments to be without merit, and I reach the same conclusion here. Respondents have raised some additional arguments in this case which were not raised in the Petrus case. I also find these arguments to be without merit.

Respondents contend that the Act is unconstitutional as applied to them. I am without authority to decide the validity of federal statutes or regulations in cases brought pursuant to the Act. 42 C.F.R. 1003.105(c); Petrus and the Eye Center of Austin, supra, at 48. I make no ruling concerning the constitutionality of the Act as it is being applied to Respondents.

However, I do have authority to rule on the factual premises and contentions of the parties as well as to interpret laws, regulations, and court decisions. I conclude that Respondents' arguments as to the applicability of the Halper decision to the facts of this case are incorrect.

The defendant in Halper was convicted in federal court of filing 65 false Medicare claims resulting in an overpayment of $585.00. Defendant was sentenced to two years' imprisonment and fined $5,000.00. Subsequently, the United States Government brought a civil action against defendant under the False Claims Act, a statute which provides for civil remedies of twice the dollar amount of that which is established as falsely claimed, plus penalties of $2,000.00 for each false claim. The government's suit was premised on defendant's conviction for all 65 claims. The District Court entered summary judgment in favor of the government on the issue of liability. However, it held that the remedy sought by the government -- penalties totalling $130,000.00 -- would violate the defendant's right not to be placed in double jeopardy. The court based its conclusion on its determination that there was a "tremendous disparity" between the civil penalty requested and the actual damages sustained by the government. It concluded that the disparity was so great as to render the penalty punitive.

The Supreme Court sustained the District Court's conclusion that imposition of a $130,000.00 penalty would be punitive in the context of the particular facts of the case. The Supreme Court held that a civil sanction constitutes punishment in those circumstances where the civil sanction serves only the traditional aims of punishment, retribution and deterrence. 109 S.Ct. at 1902. It stated that a civil penalty could operate as an unconstitutional second punishment in:

> the rare case, the case such as the one before us, where a fixed-penalty provision subjects a prolific but small-gauge offender to a sanction overwhelmingly disproportionate to the damages he has caused. The rule is one of reason: Where a defendant previously has sustained a criminal penalty and the civil penalty sought in the subsequent proceeding bears no rational relation to the goal of compensating the Government for its loss, but rather appears to qualify as 'punishment' in the plain meaning of the word, then the defendant is entitled to an accounting of the Government's damages and

> costs to determine if the penalty sought in fact constitutes a second punishment.

109 S.Ct. at 1902. The Supreme Court remanded the case to the District Court for further proceedings to determine the amount of damages sustained by the government. It also held that, in determining damages, the District Court would be permitted to impose a penalty which approximated the damages sustained by the government. The issue was not whether damages were precisely proven, but whether there existed a rational relationship between what was incurred and what was imposed.

The Supreme Court held that its decision was inapplicable to defendants who had not previously been convicted on the same offenses for which civil penalties are sought:

> Nothing in today's ruling precludes the Government from seeking the full civil penalty against a defendant who previously has not been punished for the same conduct, even if the civil sanction imposed is punitive. In such a case, the Double Jeopardy Clause simply is not implicated.

109 S.Ct. at 1903 (emphasis added).

The Halper case is distinguishable from this case on several grounds. First, there is no prior federal conviction of record in this case. The double jeopardy doctrine does not apply to a subsequent federal prosecution based on facts which led to a state conviction. Abbate v. United States, 359 U.S. 187 (1959); Chapman v. U.S. Dept. of Health & Human Services, supra, 806 F. 2d 523, 529. Therefore, the double jeopardy doctrine cannot apply in this case, even assuming the penalties, assessments, and exclusions which I impose are construed to be punitive rather than remedial.

Respondents argue that, in fact, the state criminal prosecution against Respondent Keszler was the product of a federal investigation. They contend that it was the United States which opted to impose criminal penalties against Respondent Keszler in the guise of a state criminal proceeding. Therefore, the state criminal conviction is in reality a "federal" conviction.

The fact that federal officials may have performed the investigation which resulted in state charges being brought against Respondent does not detract from my

conclusion. A state prosecution does not become a "federal" action because state authorities are assisted by a federal agency. Bartkus v. Illinois, 359 U.S. 121, 123 (1959); United States v. Russotti, 717 F. 2d 27 (2d Cir. 1983); United States v. Aleman. 609 F. 2d 298, 309 (7th Cir. 1979); United States v. Nasworthy, 710 F. Supp. 1353 (S.D. Fl. 1989).

Respondents have offered no evidence to prove that state authorities were merely carrying out the directives of federal officials, as they seem to contend. Respondents have not proven that the state action against Respondent Keszler was merely a sham or a cover for a federal prosecution. See Bartkus, supra, 359 U.S. at 122. There is nothing of record in this case to suggest that there was not a legitimate basis for state officials to independently decide to prosecute Respondent Keszler. To the contrary, the record is replete with evidence which supports a decision by state authorities to prosecute Respondent Keszler. The Texas Medicaid program, which Respondent Keszler was convicted of defrauding, is a state health care program which is supported by federal funds. Respondent's fraud against that program provided state authorities with ample motive to prosecute him, irrespective of federal involvement in the investigation.

This case is also distinguishable from Halper in that only one of the 260 claims at issue is the subject of a prior conviction. There was no adjudication and therefore, no jeopardy, for any of the claims at issue in this case except for the claim contained in count 39. Furthermore, Respondent Keszler, P.A. was not a party to that criminal case. Thus, the Double Jeopardy Clause cannot be implicated with respect to this respondent.

Finally, the penalties, assessments, and exclusions which I am imposing in this case are not punitive. The penalties and assessments are remedial because they relate to the damages sustained by the government and are not grossly disproportionate to the government's pecuniary loss. The exclusions are remedial because they protect the Medicare and Medicaid programs from untrustworthy providers and do not impose additional punishments on these providers. Greene v. Sullivan, 731 F. Supp. at 840. Therefore, no issue of a second punishment results from the remedies which I have imposed.

CONCLUSION

For the reasons set forth in this Decision, I impose assessments of $100,000.00, and penalties of $150,000.00 against Respondents, jointly and severally. I also exclude Respondents from participating in Medicare and Medicaid for ten years.

/s/

Steven T. Kessel
Administrative Law Judge