Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: April 18, 2008
Thomas E. Strebel,	)	
	)	
Petitioner,	)	Docket No. C-08-47
	)	Decision No. CR1771
-v.-	)	
	)	
The Inspector General.	)	

DECISION

Petitioner, Thomas E. Strebel, is excluded from participation in Medicare, Medicaid, and all other federal health care programs pursuant to section 1128(b)(1) of the Social Security Act (Act) (42 U.S.C. § 1320a-7(b)(1)), effective September 20, 2007. Petitioner's exclusion for three years[1] is not unreasonable as a matter of law. Act § 1128(c)(3)(D) (42 U.S.C. § 1320a-7(c)(3)(D)).

I. Background

By letter dated August 31, 2007, the Inspector General of the Department of Health and Human Services (I.G.) notified Petitioner that he was being excluded from participation in Medicare, Medicaid, and all federal health care programs pursuant to section 1128(b)(1) of the Act. The I.G. advised Petitioner that the basis for his exclusion was his conviction in the Third District Court - Silver Summit Department, Summit County, Utah, of a misdemeanor offense related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of any health care item or service. The I.G. advised Petitioner that the exclusion was for the minimum period of three years and that the exclusion was effective 20 days from the date of the letter. I.G. Exhibit (I.G. Ex.) 1.

[1] Pursuant to 42 C.F.R. § 1001.3001, Petitioner may apply for reinstatement only after the period of exclusion expires. Reinstatement is not automatic upon completion of the period of exclusion.

Petitioner requested a hearing before an administrative law judge (ALJ) by a letter dated September 20, 2007. On November 15, 2007, the case was assigned to me for hearing and decision. On November 26, 2007, I convened a prehearing telephonic conference, the substance of which was memorialized in my Order and Initial Briefing Schedule issued November 26, 2007. The I.G. requested, absent waiver of oral hearing by Petitioner, that a schedule be established for the filing of a motion for summary judgment by the I.G. Petitioner declined to waive oral hearing and I established a briefing schedule for summary judgment to which the parties agreed.

On January 10, 2008, the I.G. filed a Motion for Summary Judgment, Brief in Support of Motion for Summary Judgment (I.G. Brief), I.G. Exs. 1 through 6, and Proposed Findings of Fact and Conclusions of Law. On February 22, 2008, Petitioner filed his Memorandum in Opposition to the Inspector General's Motion for Summary Judgment (P. Brief), with exhibits (P. Exs.) 1 through 3. On March 10, 2008, the I.G. filed a Reply to the Memorandum in Opposition to the Inspector General's Motion for Summary Judgment (I.G. Reply). No objections were raised to the exhibits submitted and P. Exs. 1 through 3 and I.G. Exs. 1 through 6 are admitted.[2]

II. Discussion

A. Findings of Fact

The following findings of fact are based upon the undisputed assertions of fact in the pleadings and the exhibits admitted:

1. On February 28, 2006, Petitioner entered into a written plea agreement by which he agreed to plead guilty to the misdemeanor offense of false or fraudulent insurance claim in violation of Utah Code Annotated § 76-6-521(1)(b) (1994); to pay restitution of $26,729.80; to pay $10,000 to the Utah Department of Insurance, Fraud Division, for its investigative expenses; and to be subject to certain other conditions, including that he will not own or work in any capacity in a pharmacy. I.G. Exs. 4, at 2; 5, at 2-3, 6.

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[2] P. Ex. 1 is marked as a two-page document, and specifically, a letter to Petitioner from the I.G. dated February 22, 2007. Review of all the copies of P. Ex. 1 filed with my office revealed that I did not receive the second page of the letter marked as P. Ex. 1, Page 2 of 2. Counsel for Petitioner was contacted but could not locate P. Ex. 1, Page 2 of 2. Subsequently, the I.G. provided a copy of the I.G.'s February 22, 2007 letter to Petitioner. The copy submitted by the I.G. is not marked or admitted as evidence but will remain in the case file for reference if necessary.

2. Pursuant to the plea agreement Petitioner entered on February 28, 2006, the prosecutor agreed to reduce one charge against Petitioner from a Second Degree Felony to a Class A Misdemeanor and to dismiss a second felony count of tampering with a witness. I.G. Exs. 4, at 2; 5, at 2-3, 6.

3. On February 28, 2006, the Honorable Bruce C. Lubeck, Third District Court - Silver Summit Department, Summit County, Utah, accepted Petitioner's guilty plea and, on April 18, 2006, Petitioner was sentenced to 365 days in jail, 335 days of which were suspended; to pay a fine, and to probation for 24 months. I.G. Exs. 5, at 10; 6, at 2; P. Brief at 2.

4. Petitioner admitted as part of his plea bargain that between July 18, 2001 and December 26, 2004, he intended to defraud the insurance company Intermountain Health Care, and that he did so by intentionally and knowingly presenting false and fraudulent claims for prescriptions totaling $26,729.80. I.G. Ex. 5, at 2-3.

5. Petitioner's fraudulent claims were made in his capacity as a pharmacist and were based upon false prescriptions for medications that were not prescribed, required or delivered. I.G. Ex. 3, at 3-4; I.G. Ex. 4, at 6-8.

6. The I.G. notified Petitioner by letter dated February 22, 2007, that the I.G. was considering excluding him from participation in Medicare, Medicaid, and all federal health care programs for three years, pursuant to section 1128(b)(1) of the Act based upon his conviction. P. Ex. 1.

7. The I.G. notified Petitioner by letter dated August 31, 2007, that he was being excluded from participation in Medicare, Medicaid, and all federal health care programs for three years, pursuant to section 1128(b)(1) of the Act, effective 20 days from the date of the letter. I.G. Ex. 1.

8. Petitioner was not excluded from participation in Medicare, Medicaid, or federal health care programs by the I.G. between the date the state court accepted Petitioner's guilty plea on February 28, 2006 and the date of his exclusion on September 20, 2007.

9. Petitioner filed a timely request for hearing by letter dated September 20, 2007. I.G. Ex. 2.

B. Conclusions of Law

1. Petitioner's request for hearing was timely and I have jurisdiction over this case.

2. Summary judgment is appropriate as the only issue to be resolved is a matter of law.

3. Petitioner was convicted of a criminal offense within the meaning of section 1128(i) of the Act (42 U.S.C. § 1320a-7(i)).

4. Petitioner was convicted in a state court of a misdemeanor offense that occurred after August 21, 1996, the date of enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the offense was insurance fraud; and the offense was in connection with the delivery of a health care item or service.

5. There is a basis for exclusion of Petitioner pursuant to section 1128(b)(1) of the Act.

6. Pursuant to section 1128(c)(3)(D) of the Act, the minimum period of exclusion under section 1128(b)(1) is three years and that period is reasonable as a matter of law absent evidence of mitigating factors warranting a reduced period.

7. The three-year period of exclusion did not begin to run until September 20, 2007, 20 days after the date of the I.G. notice of exclusion. 42 C.F.R. § 1001.2002(b).

C. Issues

The Secretary of Health and Human Services (the Secretary) has limited the issues that may be appealed by an individual or entity subject to an exclusion to:

> Whether there is a basis for the imposition of the sanction of exclusion; and
>
> Whether the period of exclusion is unreasonable.

42 C.F.R. § 1001.2007(a)(1).

D. Applicable Law

Pursuant to section 1128(b) of the Act, the Secretary has the discretion to exclude certain individuals or entities from participation in Medicare, Medicaid, and other federal health care programs. Section 1128(b) provides in pertinent part:

> (b) PERMISSIVE EXCLUSION. – The Secretary may exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1128B(f)):
>
> > (1) CONVICTION RELATING TO FRAUD. – Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law-
> > > (A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct-
> > > > (i) in connection with the delivery of a health care item or service, ...

Section 1128(c)(3)(D) of the Act provides that an exclusion imposed under section 1128(b)(1) of the Act shall be for a period of three years unless the Secretary determines in accordance with published regulations that a shorter period is appropriate based on certain mitigating factors. Those factors are found in 42 C.F.R. § 1001.201(b)(3)(i)-(iv).

The underlying conviction is not subject to collateral attack or review by me on either substantive or procedural grounds. 42 C.F.R. § 1001.2007(d). The standard of proof is a preponderance of the evidence. 42 C.F.R. § 1001.2007(c). Petitioner bears the burden of proof and persuasion on affirmative defenses or mitigating factors. The I.G. bears the burden on all other issues. 42 C.F.R. § 1005.15(b) and (c).

E. Analysis

1. Summary judgment is appropriate.

Pursuant to section 1128(f) of the Act, a person subject to exclusion has a right to reasonable notice and an opportunity for a hearing. The right to hearing before an ALJ is accorded to a sanctioned party by 42 C.F.R. § 1005.2 and the rights of both the sanctioned party and the I.G. to participate in a hearing are specified in 42 C.F.R. § 1005.3. Either or both parties may choose to waive appearance at an oral hearing and to submit only documentary evidence and written argument for my consideration. 42 C.F.R. § 1005.6(b)(5). The ALJ may also resolve a case, in whole or in part, by summary judgment. 42 C.F.R. § 1005.4(b)(12). Summary judgment is appropriate and no hearing is required where either: there are no disputed issues of material fact and the only questions that must be decided involve application of law to the undisputed facts; or, the moving party must prevail as a matter of law even if all disputed facts are resolved in favor of the party against whom the motion is made. A party opposing summary judgment must allege facts which, if true, would refute the facts relied upon by the

moving party. *See, e.g.*, Fed. R. Civ. P. 56(c); *Garden City Medical Clinic*, DAB No. 1763 (2001); *Everett Rehabilitation and Medical Center*, DAB No. 1628, at 3 (1997) (in-person hearing required where non-movant shows there are material facts in dispute that require testimony); *Thelma Walley*, DAB No. 1367 (1992); *see also New Millennium CMHC*, DAB CR672 (2000); *New Life Plus Center, CMHC*, DAB CR700 (2000).

Petitioner argues that the I.G. has not presented sufficient evidence for me to determine that the period of exclusion is not unreasonable. However, as discussed hereafter the issue of whether or not the period of exclusion is unreasonable is, in this case, an issue of law that must be resolved in favor of the I.G. and against Petitioner. There are no genuine issues of material fact in dispute in this case. Accordingly, summary judgment is appropriate.

2. There is a basis for Petitioner's exclusion under section 1128(b)(1)(A)(i) of the Act.

In his request for hearing, Petitioner disputed the propriety of his exclusion, arguing that the fraudulent insurance claims that were the subject of his conviction concerned a private insurance carrier and did not involve Medicare, Medicaid, or any federal health care program. I.G. Ex. 2. Petitioner is excluded pursuant to section 1128(b)(1)(A)(i) of the Act. The elements for exclusion pursuant to section 1128(b)(1)(A)(i) are: (1) conviction in a state or federal court; (2) conviction is of a misdemeanor offense of fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; (3) the offense occurred after August 21, 1996; and (4) the offense was in connection with the delivery of a health care item or service. Petitioner does not dispute that he was convicted within the meaning of the Act by a state court pursuant to his guilty plea to a misdemeanor offense of false or fraudulent insurance claim. He does not dispute that the offense for which he was convicted occurred between July 18, 2001 and December 26, 2004, after the date of enactment of HIPAA. He also does not dispute that his fraudulent claims were made in his capacity as a licensed pharmacist and were based upon prescription medications that were not prescribed, required, or delivered. Thus, Petitioner has not disputed any of the facts that satisfy the elements for an exclusion pursuant to 1128(b)(1)(A)(i). His argument that his misconduct had no connection with Medicare, Medicaid, or any other federal health care program is without merit, as no such connection is required for exclusion pursuant to section 1128(b)(1)(A)(i). All that need be shown is that the offense of fraud was in connection with the delivery of a health care item or service. The nexus or common sense connection between Petitioner's fraud and the delivery of a health care item or service exists here because his fraudulent claims, based upon false prescriptions that were not actually prescribed, required, or delivered, were made possible by his use of his professional position as a pharmacist. *See Erik D. DeSimone, R. Ph.*, DAB No. 1932, at 5 (2004).

The material facts that provide a legal basis for Petitioner's exclusion under section 1128(b)(1)(A)(i) of the Act are undisputed. Accordingly, I conclude there is a basis for Petitioner's exclusion under section 1128(b)(1)(A)(i) of the Act.

3. Petitioner has failed to show by a preponderance of the evidence that there are any of the mitigating factors authorized by 42 C.F.R. § 1001.201(b)(3) that may be grounds for shortening the minimum three-year period of exclusion required by section 1128(c)(3)(D) of the Act.

The period of exclusion pursuant to section 1128(b)(1) is three years as mandated by section 1128(c)(3)(D), unless mitigating factors warrant reduction of that period. Only the mitigating factors authorized by 42 C.F.R. § 1001.201(b)(3) may be considered to reduce the period of exclusion. Petitioner does not argue that any of the mitigating factors authorized by the regulation are present in this case. Accordingly, I have no basis upon which to reduce the three-year exclusion in this case and I must conclude that the period is reasonable as a matter of law.

I have considered Petitioner's argument in his brief that the length of the exclusion is unreasonable due to an approximately 18-month delay between Petitioner's conviction and the I.G.'s notice of Petitioner's exclusion. P. Brief at 1-5. Petitioner argues that due to the delay he has been subjected to the 36-month exclusion required by the Act plus an additional 18 months due to the I.G. delay, a total 54-month exclusion period. Petitioner submitted a February 22, 2007 letter from the I.G. notifying Petitioner that his exclusion was being considered based on a "recent" conviction even though the conviction had occurred one year earlier. P. Ex. 1. Petitioner argues that the I.G. then failed to issue its final decision for another six months after its February 22, 2007 letter. P. Brief at 5. Petitioner asserts that I "must" consider the duration of I.G.'s delay in prosecuting the exclusion action to determine whether the length of the exclusion is reasonable. Petitioner cites *Connell v. Secretary of Health and Human Services*, No. 05cv4122, 2007 WL 1266575, and 2007 U.S. Dist. LEXIS 31590 (P. Ex. 2), in support of his argument. P. Brief at 3.

Petitioner's argument is without merit. I am neither authorized, nor required, to treat any delay as part of Petitioner's exclusion or as a mitigating factor, or to review the reason for the delay. An appellate panel of The Departmental Appeals Board (the Board) has held that the Act and regulations implementing the Act do not authorize an ALJ or the Board to retroactively adjust the beginning date of an exclusion or to review the I.G.'s decision on when the exclusion should be imposed for any reason. *Thomas Edward Musial*, DAB No. 1991, at 4-5 (2005), *citing Douglas Schram, R. Ph.*, DAB No. 1372, at 11 (1992); *David E. DeFries*, DAB No. 1317, at 6 (1992); *Samuel W. Chang, M.D.*, DAB No. 1198, at 10 (1990); *Kailash C. Singhvi, M.D.*, DAB No. 2138, at 4-5 (2007); *Lisa Alice Gantt*,

DAB No. 2065, at 2-3 (2007); *Kevin J. Bowers*, DAB No. 2143, at 6-7 (2008); *Randall Dean Hopp*, DAB No. 2166, at 3-4 (2008). The Board and I are bound by the Act and the Secretary's regulations implementing the Act.

Even the district judge and the magistrate in *Connell*, 2007 WL 1266575, recognized that the district court and ALJs are powerless as the matter is within the "exclusive province of the Secretary." P. Ex. 2, at 2; 2007 WL 1266575, at *2. In *Randall Dean Hopp*, DAB No. 2166, at 4 (2008), an appellate panel of the Board concluded that *Connell* is "not a basis for reversing the ALJ Decision regardless of the I.G.'s failure to explain the reason for the delay in imposing the exclusion. . ." I have neither the authority, nor discretion, to refuse to follow or to find invalid provisions of the Act, regulations implementing the Act, or "secretarial delegations of authority." 42 C.F.R. § 1005.4(c)(1). Here I am limited to considering only the mitigating factors in 42 C.F.R. § 1001.201(b)(3) to determine whether a downward adjustment from a three-year exclusion may be made, although not to zero (42 C.F.R. § 1005.4(c)(6)).

III. Conclusion

There is a basis for Petitioner's exclusion from participation in Medicare, Medicaid, and all federal health care programs pursuant to section 1128(b)(1) of the Act, for a period of three years, effective September 20, 2007. The period of exclusion is specified by the Act and it is not unreasonable as a matter of law.

/s/
Keith W. Sickendick
Administrative Law Judge