Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Michael D. Dinkel
(OIG File No. A-10-40001-9),

Petitioner

v.

The Inspector General.

Docket No. C-10-759

Decision No. CR2396

Date: July 12, 2011

DECISION

I exclude Petitioner, Michael D. Dinkel, from participating in Medicare and other federally funded health care programs for a period of eight years. I find that, over a period of about two and one-half years, Petitioner presented or caused to be presented claims for Medicare and State Medicaid items or services that he should have known were false or that were not provided as claimed. During this period Petitioner caused to be presented nearly 9,500 false claims seeking reimbursement for more than $1.6 million.

I. Background

Petitioner is the sole owner and President of Drew Medical, Inc. (Drew Medical), a corporation that performs diagnostic imaging services. It has eight offices in the Orlando, Florida area, and it provides outpatient radiology services that include Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans. Its clientele includes Medicare beneficiaries and recipients of Medicaid services. Drew Medical participates in the Medicare program, and its participation is governed by applicable federal statutes and regulations.

The Inspector General (I.G.) determined to exclude Petitioner, pursuant to section 1128(b)(7) of the Social Security Act (Act). Section 1128(b)(7) of the Act allows the I.G. to exclude individuals who have committed an act that is described at another section of the Act, Section 1128A. Section 1128A of the Act permits the I.G. to exclude any individual who presents, or who causes to be presented, claims for reimbursement for Medicare or State Medicaid items or services that the individual knows, or should know, are for items or services that were not provided as claimed, or that were false or fraudulent.

Specifically, the I.G. alleged that Petitioner unlawfully caused Drew Medical to file a total of 8853 false claims to Medicare and 638 false claims to the Florida Medicaid program. The allegedly false claims were filed by Drew Medical during a period that began on November 6, 2003 and that ended on May 1, 2006, and the amounts claimed totaled $1,676,777.90.

Petitioner requested a hearing, and the case was assigned to me. The parties exchanged briefs and proposed exhibits, and the I.G. moved for summary judgment against Petitioner. On February 8, 2011, I issued a ruling granting partial summary judgment in favor of the I.G. Ruling Granting Partial Summary Judgment (Ruling). I found that there was no dispute that Petitioner, in his capacity as President and sole owner of Drew Medical, had presented, or caused to be presented, all of the claims that were at issue in this case and for the amounts alleged by the I.G. I found further that these claims were for items or services that were false or that were not provided as claimed. I found that there were fact disputes as to whether Petitioner was personally culpable for these claims – that is to say, whether he knew or should have known that they were false, or for items or services that were not provided as claimed – and as to whether, and for what length of time, Petitioner should be excluded. I reserved these remaining issues to be decided after an in-person hearing.

In my Ruling, I found that Drew Medical filed reimbursement claims with Medicare and Florida Medicaid using standardized forms, either on paper or electronically. Drew Medical specified its claims on these forms using a widely recognized claims coding system known as "CPT codes." Ruling at 3. I found that the term "CPT" stands for "current procedural terminology." *Id*. CPT is a standardized shorthand methodology for particularizing the items or services that a provider may claim for reimbursement. When a provider files a claim, it identifies the CPT code that most accurately represents the item or service that it has provided, and it uses that code in its claim as a way of telling Medicare or Medicaid that it has provided an item or service and is requesting reimbursement for it. When a provider files a claim using a particular CPT code, it expressly represents to Medicare or a State Medicaid program that it has provided the item or service that is represented by the code. And, it warrants that what it has claimed is accurate and truthful. *Id.*

I found that CPT has additional importance in that the CPT code that is utilized in filing a claim determines the reimbursement that the provider receives for the item or service that is claimed. Medicare and State Medicaid programs pay a predetermined amount for an item or service described under a particular CPT code. Ruling at 3.

I concluded that, during the period at issue between 2003 and 2006, Drew Medical filed 8,853 Medicare claims and 638 Medicaid claims in amounts totaling $1,676,777.90 for items or services described at CPT code 36005. Ruling at 4. Between 1999 and 2001, the CPT described code 36005 as covering an "[i]njection procedure for contrast venography (including introduction of needle or intracatheter)." After 2001, the CPT described code 36005 as covering an "[i]njection procedure for extremity venography (including introduction of a needle or intracatheter)." *Id.* at 3. Essentially, the code's description of the procedure has remained identical since 1999, and it covers a procedure colloquially known as a venogram, a procedure whereby dye is injected into a vein to better visualize it with an x-ray or a scan. *Id.*

I found that the undisputed evidence establishes that Drew Medical never performed a venogram during the period at issue, despite the fact that Petitioner had caused it to file thousands of Medicare and Medicaid reimbursement claims for that item or service. Ruling at 4. In each instance, Petitioner billed for a venogram under CPT code 36005 in addition to the MRI or CT procedure that was actually performed, resulting in approximately an additional $600 claim per instance. The claims that Petitioner caused Drew Medical to file for items or services under CPT code 36005 during the period at issue all were false or for items or services that were not provided as claimed. *Id*.

On May 9, 2011, I held a hearing by videoconference to receive evidence as to the issues of Petitioner's culpability and remedy. I received into evidence exhibits from the I.G. that were identified as I.G. Ex. 1 – I.G. Ex. 65. I received into evidence exhibits from Petitioner that were identified as P. Ex. 1 – P. Ex. 17.[1] I heard the cross-examination and redirect testimony of several witnesses whose direct testimony had been introduced either as affidavits or by written declaration.

The parties filed pre- and post-hearing briefs. With its post-hearing brief, Petitioner filed a motion to supplement the record with two additional exhibits, an exhibit that Petitioner identified as P. Ex. 18 (an affidavit by Richard D. Dinkel executed June 22, 2011) and an additional exhibit that it identified as P. Ex. 19 (an excerpt from the 2004 CPT code book).[2] The I.G. opposed Petitioner's motion. I deny Petitioner's motion as respects P. Ex. 18, and I grant it as respects P. Ex. 19.

[1] Petitioner had listed an additional exhibit, P. Ex. 18, as a proposed exhibit but did not offer it into evidence at the hearing. Tr. at 21-22.

At the hearing I offered Petitioner the opportunity to offer an excerpt of the CPT that was not included in the parties' exhibits to clarify the record. Tr. at 150-51. That excerpt, which Petitioner offers as P. Ex. 19, is non-controversial and is, in fact, an excerpt from a document that is part of the public record. The parties could have cited to the CPT without offering any of it as evidence inasmuch as the document is a public document.

I did not, however, offer Petitioner the opportunity to expand on its case in chief or to launch a rebuttal case via post-hearing submissions. David Dinkel's affidavit is not a clarifying document, it is an attempt by Petitioner to offer new evidence to rehabilitate the testimony of another witness, Charles Marrero. Petitioner could have attempted to rehabilitate Mr. Marrero's testimony during the hearing because his counsel was granted, and exercised the right, to conduct re-direct testimony of Mr. Marrero. It is too late in the game to allow new evidence on a fact issue that is in dispute. Furthermore, admitting David Dinkel's affidavit at this point would prejudice the I.G., unless I reopened the record to allow the I.G. to cross-examine him on the contents of the affidavit. That is a step that I am not prepared to take.

II. Issues, Findings of Fact, and Conclusions of Law

A. Issues

The issues that remain to be decided are whether:

1. Petitioner is culpable for causing claims to be presented that were false or for items or services that were not provided as claimed; and

2. It is reasonable to exclude Petitioner from participating in Medicare and other federally funded health care programs.

B. Findings of Fact and Conclusions of Law

I make the following findings of fact and conclusions of law (Findings).

1. Petitioner should have known that he caused to be presented claims for Medicare and Medicaid items or services that were false or for items or services that were not provided as claimed.

The I.G. asserts that Petitioner knew that the claims that are at issue in this case were false, fraudulent, or for items or services that were not provided as claimed. Put simply, the I.G. alleges that Petitioner intentionally defrauded the Medicare and Florida Medicaid

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[2] What Petitioner now offers as P. Ex. 18 is not the same exhibit as the P. Ex. 18 that it did not offer at the hearing.

programs by causing claims to be filed that he knew were for items or services that Drew Medical never provided.

There is no question that Petitioner had a financial incentive to file false claims. The claims that Petitioner caused to be presented during the period that is at issue in this case were for more than $1.6 million in reimbursement that Drew Medical had no right to claim. Payments received by Drew Medical for these false claims constituted improper enrichment of that entity, which certainly inured to Petitioner's – the sole owner of Drew Medical – personal financial benefit. I.G. Ex. 7 at 269; I.G. Ex. 16.

But, the possibility of improper enrichment standing alone is not sufficient to establish willful fraud. What is lacking from the I.G.'s case for intentional fraud is evidence showing that Petitioner willfully directed his company to file false claims knowing that these claims were false. The I.G. did not offer proof, for example, that Petitioner personally planned and directed the use of CPT code 36005 to make reimbursement claims for items or services that he knew Drew Medical had not provided or that there was any discussion between Petitioner and his staff at which the idea of a deliberate fraud was broached.

However, there is an abundance of evidence establishing that Petitioner was indifferent to the propriety of claiming reimbursement using CPT code 36005 and that he acted in reckless disregard of the requirements that governed filing claims for the items or services that were provided by Drew Medical. I find the evidence establishing reckless conduct by Petitioner to be overwhelming. Thus, although the evidence does not prove that Petitioner intentionally defrauded federally funded health care programs, it proves that Petitioner should have known that the claims that he caused to be presented were false or were for items or services that were not provided as claimed. Consequently, Petitioner is liable under sections 1128A and 1128(b)(7) of the Act.

The evidence does not support Petitioner's assertion that he made only honest errors. The evidence establishes a wholesale indifference on Petitioner's part to the propriety of the claims he caused Drew Medical to present. That indifference was not some minor omission involving a few claims or a small sum of money. What was involved here is a huge sum of money, more than $1.6 million, and many thousands of false claims.

Petitioner had a duty, as sole owner and President of Drew Medical, to understand Medicare and Medicaid billing requirements and to apply them scrupulously to the claims that he caused to be presented. *Cary Frounfelter and Kast Orthotics and Prosthetics, Inc.*, DAB CR1808 (2008), *aff'd*, DAB No. 2211 (2008). Petitioner was aware of and understood that duty. In Petitioner's own words:

> You know, I'm the owner of Drew Medical. The buck stops with me.

Tr. at 138.

And, with respect to CPT codes, Petitioner admitted that:

> I'm obligated to know what that book says and intent from the pure focus that if you are going to be in the Medicare program you are being relied on to do what is correct.

Id. at 145.

That duty required Petitioner to do more than delegate to others the responsibility for establishing which codes should be utilized for filing claims. Petitioner – as he acknowledged – was *personally responsible* for assuring that Drew Medical claimed reimbursement appropriately and that it did not seek reimbursement for items or services that it did not provide.

Petitioner failed to discharge that duty. His failure constituted reckless indifference to the propriety of the claims he caused to be presented. He failed until some time in 2006 or 2007 even to read Part 70000 of the CPT code, the provisions relating to radiology services, including those types of services that were actually performed by Drew Medical. Tr. at 120.

Petitioner also disregarded the obvious language of CPT code 36005, language that I find would have put any reasonable provider on notice that he could not use the section in conjunction with claims for MRIs and CT scans. Petitioner read this section in 2004 only after a member of Drew Medical's staff showed it to him and after Drew Medical had been filing claims pursuant to that code for several years. Tr. at 112-14; P. Ex. 2 at 89. As I shall discuss, that language, standing alone, put Petitioner on notice that use of the code by Drew Medical was improper.

What would have been obvious to Petitioner, had he bothered to read the radiology codes in conjunction with CPT code 36005, is that CPT code 36005 may not be used as a means of capturing the administration of contrast material to a beneficiary receiving an MRI or a CT scan. The radiology codes that covered these procedures were global in the sense that they did not allow for separate claims for administration of contrast material. It is patently clear that one may not claim reimbursement for a venogram as a way of enhancing or augmenting the global MRI and CT scan reimbursements.

That is obvious from the plain language of CPT code 36005, from the context of this language within the CPT, and from the CPT's description of the procedures that Drew Medical actually performed. The text of CPT code 36005 is by itself sufficient to forewarn a provider not to use this code for something other than its stated purpose. Code 36005 specifically applies to claims for the performance of venography. This is a

diagnostic procedure that is totally different from MRIs and CT scans and is a procedure that Drew Medical never performed. No reasonable provider experienced in the performance of CT scans and MRIs would confuse these procedures with venograms. I.G. Ex. 18 at 2-4, 9. I find it inconceivable that Petitioner would have failed to understand that distinction had he made an effort to comprehend CPT code 36005.

There is more in the CPT than just the plain language of CPT code 36005 that would put any reasonable provider on notice that CPT code 36005 may not be used to claim reimbursement for administration of contrast material to recipients of MRIs or CT scans. Radiology services, including MRIs and CT scans, are covered by Part 70000 of the CPT. CPT code 36005 is in an entirely different part of the code. That fact served as an obvious warning that CPT code 36005 was intended to cover a completely different procedure than an MRI or a CT scan. Petitioner would have recognized that immediately had he read Part 70000.

Furthermore, the text in Part 70000 of the CPT relating to radiology procedures specifically refers to the administration of contrast materials in connection with the performance of those procedures. Part 70000 makes it plain that the administration of contrast in connection with the performance of a MRI or CT scan is part of the global procedure and not something for which reimbursement may be claimed separately:

> Injection of intravascular contrast material is part of the "with contrast" CT, CTA, MRI, MRA procedure.
>
> Oral and/or rectal contrast administration alone does not qualify as a study "with contrast."

I.G. Ex. 14 at 5 (*see* Part 6a).

Petitioner claims that the CPT is ambiguous and that he was misled by the CPT's ambiguity into believing that Drew Medical could file claims under code 36005. Tr. at 117-18, 144-45. Petitioner's claim of ambiguity reduces to the argument that he could take advantage of any perceived ambiguities in the CPT to file Medicare claims as he saw fit. That is impermissible. If Petitioner thought that the CPT was ambiguous, then he had the obligation to resolve those ambiguities.

In fact, the evidence does not paint a picture of an individual who was baffled by an allegedly ambiguous document and who struggled to obtain a clear understanding of its meaning. To the contrary, it shows Petitioner to have been serenely indifferent to the directives of the CPT. There is no evidence that Petitioner ever expressed any concern to anyone about alleged ambiguities in the CPT. Nor is there evidence that, prior to January 2006, Petitioner directed his staff to research the relevant code provisions and to report back to him with an opinion as to how they should be applied.

Furthermore, Petitioner has offered no evidence to establish that anyone outside of Drew Medical ever determined the CPT to be ambiguous as respects radiology procedures. He has not identified even a single instance of a provider other than himself allegedly having problems reading and understanding the CPT sections that are at issue here. He has produced no documentation from Medicare showing that Medicare ever experienced complaints about the relevant portions of the CPT's alleged ambiguity.

Petitioner asserts that, in July 2006, a representative of the Medicare contractor advised Petitioner that the relevant portions of the CPT were ambiguous. I find no support for this assertion. Petitioner's "proof" is an e-mail that a representative of the Medicare carrier sent to an agent for Drew Medical on July 13, 2006. The e-mail reads:

> I wanted to let you know that your request for clarification of MRI and CT billing codes and contrast has been referred to me for further research. As *you stated* these guidelines can be a little confusing, so I want to be sure that I research these issues thoroughly. . . .

P. Ex. 3 (emphasis added).

That is hardly a concession that the overall CPT is ambiguous, and it is certainly not a statement that CPT code 36005 is in any respect ambiguous. Rather, it is a mild expression of agreement by the carrier's representative with Drew Medical's agent's contention that the CPT codes in general "can be a little confusing." The carrier's representative understandably was expressing caution before stating an unqualified opinion.

I note that Petitioner did not produce any follow-up communications from this individual. There is nothing to suggest that the carrier's representative actually found the CPT codes at issue in this case to be ambiguous.

Not only did Petitioner fail to read the unambiguous language of the CPT but he failed to institute reviews at any time prior to 2006 that should have revealed Drew Medical's improper claims. In 2004, the Agency for Health Care Administration (AHCA), a Florida State agency, conducted an inspection and instructed Drew Medical to institute a system of systematic claims reviews. I.G. Ex. 31; FLA. STAT. § 400.9935(g). However, Drew Medical did not conduct systematic audits of its claims prior to January 2006. I.G. Ex. 7 at 266-67; I.G. Ex. 20 at 54; I.G. Ex. 32.

Petitioner argues that, from 2000 until now, its employees have conducted monthly billing audits and an annual coding review. As support for this contention, Petitioner relies on an affidavit filed by Charles Marrero, a former employee of Drew Medical who served as that entity's billing systems administrator from 1998 until 2002. P. Ex. 9. Below, I explain why I find Mr. Marrero generally not to be a credible witness. But,

leaving overall issues of credibility aside, I find Mr. Marrero's testimony does not substantiate Petitioner's contention that its employees have been conducting monthly billing audits.

Mr. Marrero's affidavit says nothing about monthly billing audits. He contends that he, along with another employee, Andrea Shelton, "reviewed all Medicare updates pertaining to radiology on a monthly basis." P. Ex. 9 at 2. That is not a billing audit but at most a review of Medicare reimbursement publications. Moreover, Mr. Marrero left Petitioner's employ a year prior to the events that are at issue in this case. He would have no way of knowing whether Petitioner performed monthly billing audits between November 2003 and May 2006. Finally, I note that Petitioner has produced no other evidence pertaining to its alleged monthly billing audits. Thus, its contention that its staff performed these audits is a naked assertion without evidentiary support.

The plain and unambiguous language of the CPT was not the only notice of obviously improper claims that Petitioner ignored. Petitioner was told by members of his own staff that Drew Medical was filing improper claims. Petitioner ignored this advice.

There is overwhelming evidence that members of Drew Medical's staff became convinced as early as the autumn of 2003 that it was wrong to file reimbursement claims pursuant to CPT code 36005. These concerns worked their way up Drew Medical's chain of command, prompting exchanges of e-mails and numerous discussions among the staff. On August 4, 2004, Randi Terry, Drew Medical's radiology information systems manager – who reported directly to Petitioner – told Petitioner that the use of CPT code was improper. In an e-mail to Petitioner and other personnel on that date, she stated that:

> MANY conversations occurred yesterday regarding using code 36005 on with and without [contrast] procedures. Most of the billing people do not think that it is appropriate to be using it. MIKE [Petitioner], Luis [Velasquez, an employee of Drew Medical] has some documentation regarding this. After a conversation with Doug [Dinkel], I have decided to wait for a response from MIKE before changing any of these. Mike, please respond to me when you get a chance to read the documentation. . . Thanks and welcome back!!!!!!!!!

I.G. Ex. 30; *see* I.G. Ex. 36 at 196.

On subsequent occasions in 2004 Petitioner was told that Drew Medical employees believed that use of CPT code 36005 was wrong. I.G. Ex. 12 at 232, 234-35; I.G. Ex. 35

at 61.[3] In spite of these objections, Petitioner continued use of the code in November 2004, and, after a meeting with his staff, Petitioner decided that Drew Medical would continue to use CPT code 36005 in conjunction with its claims for MRIs and CT scans. I.G. Ex. 7 at 220, 225-27. It was not until the end of January 2006 that Petitioner finally instructed his staff to cease using CPT code 36005. However, Drew Medical continued to submit claims using this code until May 1, 2006. I.G. Ex. 1 at 177; *see generally* I.G. Ex. 1 Attachment C.

Petitioner denies being directly confronted by his staff about the impropriety of using CPT code 36005. For example, he asserts that he never saw the e-mail that Ms. Terry sent to him on August 4, 2004. He contends that the discussions that he had with his staff about the use of CPT code 36005 did not center on the overall propriety of Drew Medical's use of the code but on the use of the code for certain very narrowly defined types of claims. Petitioner asserts that his meeting with his staff in November 2004 centered around whether CPT code 36005 could be used when the claim was for oral – as opposed to injected – contrast material. Tr. at 111-15. However, Petitioner also asserts that the November 2004 meeting was about whether CPT code 36005 could be used for claiming reimbursement for peripheral items used in conjunction with MRIs and CTs, such as needles, gloves, and the use of a power injector. Tr. at 112-23.

I find these denials to be self-serving and not believable. It is evident from the communications among Drew Medical's staff in the year prior to the November 2004 meeting that their concern was that using CPT code 36005 as a routine addendum to CT scan and MRI reimbursement claims was improper. Several e-mails between members of the staff clearly establish that this was their concern. I.G. Ex. 34; I.G. Ex. 43; I.G. Ex. 44; I.G. Ex. 45. The tone of these e-mails becomes increasingly urgent as staff continue to express their discomfort with continued use of the code as a general add-on to reimbursement claims for radiology procedures. None of these e-mails suggest that the staff's concern centered on the narrow questions of whether the code could be used to claim reimbursement for oral, as opposed to injected, contrast, or whether the code could be used to claim reimbursement for peripheral items. I do not find that the staff – after having expressed their concerns so often and with such intensity – would fail to bring them to Petitioner's attention in person when he gave them the opportunity to do so.

I also find not believable Petitioner's self-serving assertion that he did not see the August 4, 2004 e-mail from Ms. Terry. *See* Tr. at 129. Petitioner contends, variously, that: his computer may have been "rebooted" and "reset," thereby deleting the e-mail before he

[3] I.G. Ex. 12 consists of excerpts from a transcript of a deposition of Andrea Shelton, a former employee of Drew Medical. My citations to this exhibit are to the pages of the deposition transcript rather than to the actual page of the exhibit. I do so with this exhibit and other similar transcript excerpts because that more precisely identifies where within the exhibit the cited testimony may be found.

read it; the e-mail was addressed to the "Administration" list serve, which he did not read because he found e-mails on that list to be irrelevant; and he did not read the e-mail because he was out of town at the time that it was sent to him. P. Ex. 2 at 87-88, 90. The shifting nature of these explanations undermines the credibility of all of them.

As support for his assertion that he was never made aware of the actual concerns of his staff, Petitioner contends that Drew Medical's employees never expressed serious concerns to his chief manager about the proper use of CTP code 36005. To that end, Petitioner offers the affidavit of Andrea Shelton, Petitioner's former manager of billings and collections. I find her testimony not to be credible. For example, Ms. Shelton asserts that:

> to the best of my knowledge, everyone in the Billing and Collections Department believed that 36005 was a proper code to bill when patients received a contrast injection.

P. Ex. 5 at 2.

This statement is simply unbelievable in the face of the many communications prior to 2006 from staff who were concerned about the use of CPT code 36005. For example, in August 2004, Ms. Terry clearly expressed concerns about the use of the code that reflected not only her beliefs, but those of other staff as well. I.G. Ex. 30. The volume and persistence of the staff's concerns renders it improbable that Petitioner's senior billing manager was unaware of them. However, if, in fact, Ms. Shelton was unaware of the staff's concerns, that proves only that she, like Petitioner, had the ability to blind herself to what was going on around her.

Petitioner also asserts that Medicare told Drew Medical that its use of CPT code 35006 was appropriate. Petitioner's assertion is based on the testimony of Charles Marrero. According to Mr. Marrero, he consulted with a representative of Medicare (actually, an employee of a Medicare carrier) named Betty Williams-Davis, both over the telephone and in person, and she gave Drew Medical the green light to use CPT code 36005 in conjunction with reimbursement claims for MRIs and CT scans. P. Ex. 9 at 2-3.

I find this assertion to be unbelievable for several reasons. First, neither Petitioner nor Mr. Marrero produced even a shred of corroborating evidence. There is no evidence of any correspondence between Mr. Marrero and Ms. Williams-Davis discussing the code, nor is there any internal Drew Medical documentation of these purported conversations. Mr. Marrero asserted that he made a written record of his conversations with Ms. Williams-Davis. Tr. at 190-91. However, Petitioner failed to produce this alleged record.

Second, Mr. Marrero was an unreliable witness. He averred, both at the hearing and in a prior statement, that he implemented Drew Medical's use of CPT code 36005 some time in 2000. Tr. at 187; P. Ex. 9 at ¶ 10. However, in another affidavit, he asserted that he implemented the use of the code only after he spoke with Ms. Williams-Davis at a Medicare reimbursement seminar in Lakeland, Florida that purportedly occurred some time in 2001 or 2002. P. Ex. 39 at ¶ 11.

In contrast, I find Ms. Williams-Davis' testimony to be credible. She averred that cardiology, and not radiology, was her specialty when she worked for the Medicare carrier. Tr. at 46. She denied ever having given advice to Mr. Marrero about the use of CPT code 36005. She denied having met or spoken with him until 2006, at a point in time after the events that are the subject of this case had transpired. *Id.* at 49-50. She testified that she would never have advised any provider – including Drew Medical – about claims issues without creating a written record of the communication. *Id.* at 52.

Ms. Williams-Davis testimony is credible for two reasons. There are no inconsistencies in her testimony. Furthermore, her assertion that she would not have rendered advice about what may be claimed without creating a paper trail is believable. The advice that Ms. Williams-Davis gave potentially had a significant pecuniary impact on providers and on Medicare, and it only stands to reason that she would want to protect the program by documenting what she said.

Petitioner had ample discovery opportunities in this case and in civil litigation involving issues that are identical to those that are at issue here. He has not unearthed any written record from Medicare or its carrier of any communications between Ms. Williams-Davis and Mr. Marrero.

Petitioner's contentions about what Mr. Marrero purportedly learned from Medicare also are irrelevant. Mr. Marrero never communicated to Petitioner any of the information that he allegedly obtained from Ms. Williams-Davis. Tr. at 177. Petitioner cannot now claim to have relied on something that never was told to him.

2. An exclusion of eight years is reasonable.

An exclusion of Petitioner is authorized because he should have known that the reimbursement claims that he caused to be presented to Medicare and Florida's Medicaid program were false or for items or services not provided as claimed. The remaining issue to be decided is: what length of exclusion is reasonable?

The purpose of any exclusion imposed pursuant to sections 1128 and 1128A of the Act is remedial. The objective of an exclusion is not to punish a provider but to protect federally funded health care programs and the beneficiaries and recipients of program funds from individuals who are established to be untrustworthy.

An implementing regulation establishes the criteria for deciding what is the reasonable length of an exclusion imposed pursuant to section 1128(b)(7) of the Act. 42 C.F.R. § 1001.901. There are five applicable criteria, consisting of:

> (1) The nature and circumstances surrounding the actions that are the basis for liability, including the period of time over which the acts occurred, the number of acts, whether there is evidence of a pattern and the amount claimed;
>
> (2) The degree of [the excluded individual's] culpability;
>
> (3) Whether the individual . . . has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral);
>
> (4) The individual . . . has been the subject of any other adverse action by any Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for the imposition of the exclusion; or
>
> (5) Other matters as justice may require.

42 C.F.R. § 1001.901(b)(1)-(5).

Applying these criteria to the evidence in this case plainly supports an exclusion of eight years. An eight-year exclusion is a very serious remedy. I am mindful of the impact that such a remedy will have on Petitioner, personally. But, the seriousness of his misfeasance and the impact that it had on the integrity of federally funded health care programs establishes Petitioner to be highly untrustworthy.

The misfeasance in this case was extremely serious. Petitioner caused Drew Medical to submit over 9,500 false claims over a period of nearly three years, seeking unjustified reimbursement of more than $1.6 million. Moreover, these false claims and the reimbursement Petitioner claimed for them constitutes only the tip of the iceberg. The undisputed evidence in this case is that Drew Medical began making false claims pursuant to CPT code 36005 in 2000, more than three years prior to the period that is directly at issue. That pattern of false claims, extending over a period of six years, is evidence of a very high degree of untrustworthiness.

Petitioner's culpability for these false claims is very high. It is true that the evidence in this case falls somewhat short of proof that Petitioner deliberately set about to defraud Medicare and the Florida Medicaid program. But, the evidence establishes that Petitioner was utterly indifferent to the consequences of his actions. Petitioner chose not to know

whether what he was doing was right, when he failed to read the reimbursement codes that governed the claims that Drew Medical presented and when he ignored the concerns expressed to him by his staff.

I find little difference between the level of culpability manifested by a person who deliberately defrauds and one who files claims indifferent to their truth. In either instance, the perpetrator takes advantage of the entity receiving the claims to enrich himself or herself. The consequences of the unjust enrichment are identical in each case. The damage to the integrity of the programs is no less in the case of reckless indifference to the truth than it is with deliberate fraud. Thus, while fraud may have criminal consequences and reckless indifference to the truth may not, the impact of the unlawful conduct is the same in either instance.

Furthermore, a reckless individual may be just as untrustworthy as a calculating criminal. In either case, the individual who perpetrates the wrongdoing is unconcerned about the consequences of his or her actions. In either case the perpetrator acts out of indifference to the possibility that real injury may be caused by his or her disregard for the law and what is right.

Petitioner has no history of prior wrongdoing.[4] That may not be a basis for increasing the length of the exclusion but neither is it a basis for mitigating it. 42 C.F.R. § 1001.901(b)(3). Nor is there evidence of other adverse administrative actions against Petitioner.

I have taken into consideration the fact that Petitioner ordered Drew Medical to return about $700,000 of its ill-gotten reimbursement to Medicare beginning in January 2006. This voluntary act is a mitigating factor. I might have sustained an exclusion of more than eight years had Petitioner had not made partial voluntary restitution. But, the fact that he ordered restitution does not convince me that he is trustworthy.

The restitution that Petitioner ultimately ordered must be considered in the context of Petitioner's indifference to reimbursement criteria and his utterly unpersuasive explanations for his indifference. As I have said, the impact of Petitioner's recklessness on program integrity is indistinguishable from that which would have been caused by criminal fraud.

Finally, Petitioner asserts that an exclusion will effectively put him out of business and force the shutdown of Drew Medical. That, according to Petitioner, will put many individuals out of work. But, the consequences Petitioner describes are not a necessary

[4] Petitioner was a defendant in a *qui tam* lawsuit involving the same facts and similar issues as are at stake here. However, that case evidently was settled, and I am unaware of a finding of civil wrongdoing resulting from that case.

outcome of an exclusion. The exclusion applies to Petitioner and not to the company he owns and operates. Nothing prohibits Petitioner from severing his interest from Drew Medical. Presumably, the entity may continue under different ownership so long as Petitioner has nothing to do with it. Furthermore, Petitioner has not presented evidence showing the actual impact of an exclusion on the Orlando, Florida community. There is no evidence in the record proving, for example, that an exclusion of Petitioner – even if it results in a cessation of Drew Medical's operations – would adversely affect patient access to health care services.

/s/
Steven T. Kessel
Administrative Law Judge