Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
The Inspector General,	)	DATE: June 5, 1995
	)	
- v. -	)	
	)	
Jesusa N. Romero, M.D.,	)	Docket No. C-94-379
	)	Decision No. CR380
Respondent.	)	
	)	

DECISION

In a determination letter (Notice) dated May 12, 1994, the Inspector General (I.G.) proposed to impose against Respondent civil monetary penalties of $115,500, an assessment of $113,280 (which in combination with the penalties totals $228,780), and a five-year exclusion. The I.G.'s Notice was based upon her determination that Respondent had presented or caused to be presented 77 false claims representing 231 line items or services to the California Department of Health Services (Medi-Cal)[1] for services provided by Respondent during a period in which Respondent knew, had reason to know, or should have known that she was excluded from participation in Medi-Cal. The I.G. alleged that by presenting these claims Respondent violated section 1128A of the Social Security Act (Act) and its implementing regulations at 42 C.F.R. § 1003.100 et seq. By letter of June 20, 1994, Respondent requested a hearing before an administrative law judge. The case was assigned to me for a hearing and a decision.

On July 27, 1994, Respondent made a motion for summary judgment, alleging that the I.G. did not have a basis upon which to sanction her. In a September 16, 1994

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[1] The California Department of Health Services administers the Medicaid program in the State of California. California's Medicaid program is referred to as Medi-Cal. It is a State health care program as defined in subsection (h) of section 1128 of the Social Security Act (Act).

Ruling, I denied that motion and set the case for hearing.[2] I conducted an in-person hearing in Los Angeles, California on October 31, 1994. Based on the entire record before me,[3] I now conclude that the I.G. has no basis or authority to impose penalties, an assessment, or an additional period of exclusion against Respondent.

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[2] By letter of March 17, 1995, I informed the parties that I would be reconsidering my September 16, 1994 Ruling in light of the record developed at the October 31, 1994 hearing and in consideration of the posthearing submissions of the parties. Upon reconsideration, and having the benefit of a complete record, I have reached a different conclusion.

[3] The record before me consists principally of the transcript of the October 31, 1994 hearing and the briefs and exhibits submitted by the parties. During the October 31, 1994 hearing, I admitted into evidence the I.G.'s exhibits 1 through 13 and rejected I.G. exhibits 14 and 15. I admitted into evidence also Respondent's exhibits 1 through 4. With her posthearing briefs, the I.G. submitted multiple attachments which she has re-submitted as proposed I.G. exhibits 16 through 21. While Respondent opposes the inclusion of such documents as exhibits, I do not find that Respondent is harmed or prejudiced by my accepting such documents into the record. Moreover, these documents provide important factual information upon which I have based my conclusion that the I.G. has no authority to impose any penalty, assessment, or additional period of exclusion based on Respondent's submission of claims to Medi-Cal. Thus, I am admitting into evidence I.G. exhibits 16 through 21.

In this Decision, I will refer to the transcript of the October 31, 1994 hearing as Tr. at (page). I will refer to the parties' exhibits as I.G. or Respondent (R.) Ex(s). (number) at (page). I will refer to the parties' posthearing briefs as I.G. or R. Br. at (page). I will refer to the parties' responses as I.G. or R. R. Br. at (page). I will refer to the parties' supplementary briefs as I.G. or R. Supp. Br. at (page). I will refer to Respondent's supplementary response brief as R. Supp. R. Br. at (page). I will refer to the parties' joint stipulations of fact as Jt. Stip. (number).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Beginning in 1980, and continuing until her relocation to California in 1988, Respondent practiced medicine in Louisiana. Tr. at 166-167, 171.

2. In 1987, Respondent was convicted of 28 counts of Medicaid fraud in Louisiana, based on her billings to Louisiana Medicaid. State of Louisiana v. Romero, 574 So. 2d 330 (La. 1990) aff'g 533 So. 2d 1264 (La. App. 3d Cir. 1988), reh'g denied.

3. By letter of January 11, 1988, the Louisiana Department of Health and Human Resources (LDHHR), the State agency in Louisiana responsible for excluding providers from Louisiana Medicaid, suspended Respondent from Louisiana Medicaid for five years, effective January 26, 1988. I.G. Ex. 19.

4. For the purposes of the Act and of the regulations applicable to this case, the terms exclusion and suspension denote the same action; barring an individual or entity from submitting claims for reimbursement from Medicare or Medicaid for items or services provided to Medicare beneficiaries or Medicaid recipients which would otherwise be reimbursable by these programs.

5. There is no information of record to indicate whether Respondent ever appealed the determination of the LDHHR to suspend her for five years.

6. By letter of May 18, 1988, the I.G. notified Respondent that, based on her conviction of a criminal offense related to Medicaid and pursuant to section 1128(a) of the Act, she would be excluded for a period of 10 years from participation in Medicare and any State health care program as defined in section 1128(h) of the Act. I.G. Ex. 1 at 1.

7. The May 18, 1988 letter advised Respondent: (1) that no payment would be made to Respondent by Medicare or a State health care program for any items or services (other than an emergency item or service) which she furnished, ordered, or prescribed during her period of exclusion; (2) that the I.G. would notify the appropriate State or local authority having responsibility for her licensing or certification and would request that authority to invoke sanctions according to State law or policy; (3) that if, after the effective date of the exclusion (20 days after May 18, 1988 (June 7, 1988)), Respondent submitted claims for items or services furnished by her, she might be subject to a civil

monetary penalty under 42 U.S.C. § 1320a-7a (section 1128A of the Act) i.e., an assessment of not more than twice the amount claimed and a penalty of not more than $2000 per item or service claimed; and 4) that the I.G. was required to notify the appropriate State agency of Respondent's exclusion, and that the State agency was required to exclude Respondent for 10 years, the period of Respondent's Medicare exclusion. I.G. Ex. 1 at 1-2. 8. Also by letter of May 18, 1988, the I.G. notified the LDHHR of Respondent's 10-year exclusion. The I.G. directed the LDHHR to exclude Respondent from Louisiana Medicaid for the same period. I.G. Ex. 2.

9. Respondent did not pursue an appeal of the exclusion imposed against her by the I.G.'s notice letter of May 18, 1988. Jt. Stip. at 4.

10. There is no information of record to indicate whether LDHHR ever conformed to the I.G.'s 10-year exclusion by revising the five-year suspension it imposed against Respondent on January 11, 1988.

11. The I.G. prepares and disseminates to all State Medicaid agencies a cumulative national list of providers that the I.G. has excluded from participating in Medicare, titled the Cumulative Sanction Report (CSR). The I.G. prepares and disseminates also a monthly list of providers that the I.G. has excluded from participating in Medicare. I.G. Ex. 16; Tr. at 132.

12. The CSR identifies the provider by name, date of birth, specialty, and address, and also indicates the basis for the exclusion, the date of the notice of exclusion, and the period of exclusion. I.G. Ex. 16.

13. The copy of the CSR reflecting sanctions in effect as of October 31, 1988 contained the Respondent's name -- Jesusa N. Romero, her specialty -- obstetrician, her address -- 120 W. 4th Street Suite 1, DeQuincy, LA 70633, the basis of her exclusion -- section 1128(a)(1) of the Act, the date of the notice of exclusion -- May 18, 1988, and the period of her exclusion -- 10 years. I.G. Ex. 16.

14. Medi-Cal received the CSR containing the information pertaining to Respondent by December 1988. I.G. Ex. 17.

15. Respondent moved to California in 1988 and began practicing medicine. Initially, Respondent treated Medi-Cal patients but did not bill Medi-Cal for their treatment. Tr. at 171, 201.

16. On February 9, 1990, Respondent submitted an application to be assigned a Medi-Cal provider number. I.G. Exs. 10, 17.

17. Respondent did not submit the application herself. Instead, Respondent directed an independent billing company, Unlimited Physicians Services, to submit her application. I.G. Ex. 10; Tr. at 77-79, 93-94, 99, 173-174, 183, 204-206, 209-210.

18. Respondent asserts that Unlimited Physicians Services applied for a Medi-Cal provider number for her in order to accommodate her participation in a program operated by the County of Los Angeles. Respondent's Proposed Findings of Fact and Conclusions of Law, page 6, paragraph 28.

19. Respondent did not tell the employees of Unlimited Physicians Services who submitted her application for a Medi-Cal provider number about her conviction in Louisiana and subsequent exclusion by the I.G. Tr. at 79-80, 86, 174-175, 180-182, 204-206.

20. In her February 9, 1990 Medi-Cal provider application, Respondent stated, among other items of information, her name -- Jesusa N. Romero, the address of her practice -- Romero Medical Clinic, 7750 Katella Ave., Ste. 207, Stanton, CA 90680, her specialty -- "OBGYN," and her social security number. I.G. Ex. 10.

21. In 1990, the Medi-Cal provider application did not ask specifically whether an applicant had been excluded or suspended from Medicare or Medicaid or whether an applicant had been convicted of Medicaid fraud. I.G. Ex. 10. The application was amended in 1993 to include a question as to whether an applicant had been suspended from Medicare or Medicaid. Tr. at 135-137.

22. Respondent's application did not reflect that she had been excluded from Medicare by the I.G. or that she had been convicted of Medicaid fraud in Louisiana and suspended from participation in Medicaid by Louisiana Medicaid. I.G. Ex. 10.

23. In 1990, the Medi-Cal provider application required a certification that the information provided in the application be true, accurate, and complete to the best of the applicant's knowledge. The application stated also that incorrect or inaccurate information might affect the applicant's eligibility to receive Medi-Cal reimbursement. I.G. Ex. 10.

24. Medi-Cal did not do an independent investigation of Respondent to determine whether she had been excluded from Medicare or from Medicaid in another State. Tr. at 128-129.

25. When Respondent applied for a Medi-Cal provider number on February 9, 1990, Medi-Cal officials reviewed their list of California-based providers to determine whether Respondent had been suspended from participating in Medi-Cal or Medicare. I.G. Ex. 17.

26. In February 1990, due to budget constraints, there was insufficient staff in the Medi-Cal Provider Services Section (the office responsible for processing applications for Medi-Cal provider numbers) to review the CSR to identify whether Respondent was previously excluded from Medicare or from a Medicaid program in another state. Consequently, Medi-Cal never checked Respondent's name against the CSR. Tr. at 129, 131-135; I.G. Ex. 17.

27. A cursory examination of the CSR by Medi-Cal would have identified information regarding Respondent (the same name and similar specialty) which should have alerted them that Respondent might be the provider identified in the CSR. I.G. Ex. 16.

28. Medi-Cal asserts that, absent identification of Respondent's social security number in the CSR, Medi-Cal could not have ascertained that the individual referenced in the CSR as Jesusa N. Romero, M.D., obstetrician, was, in fact, Respondent. I.G. Ex. 17.

29. Due to Medi-Cal's inability to conduct an inquiry into Respondent's past status as a Medicare provider or a Medicaid provider in another State, and considering that Respondent might not be the same provider identified in the CSR, Medi-Cal officials were more concerned with the possibility of erroneously withholding a provider number from a potentially legitimate provider than with the possibility that a provider who had been excluded previously by the I.G. might be permitted to provide medical services to Medi-Cal recipients. Tr. 128-137; I.G. Ex. 17.

30. Respondent received a Medi-Cal provider number on or about March 7, 1990. Jt. Stip. at 7; Respondent's Proposed Findings of Fact and Conclusions of Law at page 4, paragraph 19.

31. Medi-Cal officials were unaware of Respondent's exclusion when they issued her a provider number in 1990. Tr. at 130.

32. Medi-Cal would not have issued Respondent a Medi-Cal provider number had Medi-Cal known of her exclusion, since one of the requirements of Medi-Cal eligibility is that an applicant not have been excluded from Medicare or from any Medicaid program. Tr. at 120-121, 130.

33. Medi-Cal authorizes providers who have received a Medi-Cal provider number to submit claims for up to one year prior to the approval of their Medi-Cal provider application. Tr. at 130-131.

34. Respondent authorized Unlimited Physicians Services to submit claims to Medi-Cal on her behalf. Tr. at 74, 96-97, 187-189.

35. Respondent admits that she submitted, via Unlimited Physician's Services, "various" claims to Medi-Cal's fiscal intermediary on July 19, 1990, four additional claims on August 17, 1990, and one claim on August 19, 1990. Respondent's Proposed Findings of Fact and Conclusions of Law at page 3, paragraph 13.

36. After receiving Respondent's Medi-Cal provider number, Unlimited Physicians services submitted 77 claims representing 231 line items to Medi-Cal for reimbursement of the services Respondent provided to Medi-Cal recipients between March 13, 1989 and August 1, 1990. I.G. Ex. 7; Tr. at 160.

37. On November 28, 1990, Medi-Cal suspended Respondent's participation in Medi-Cal "effective the date of this letter." I.G. Ex. 3.

38. Medi-Cal suspended Respondent's participation based on information supplied by the I.G. that Respondent had been excluded from Medicare for 10 years effective June 7, 1988. I.G. Ex. 3.

39. Medi-Cal informed Respondent that, pursuant to California law, Medi-Cal must suspend a provider from Medi-Cal "for the same period as the practitioner is suspended from ... Medicare." I.G. Ex. 3.

40. All of the Medi-Cal claims at issue in this proceeding (upon which the proposed penalties, assessment, and exclusion are based), predate Respondent's November 28, 1990 suspension from Medi-Cal.

41. Medi-Cal will reimburse Respondent for all claims she submitted pursuant to her provider number (for services she provided to Medi-Cal patients), so long as those claims predated the effective date of her Medi-Cal exclusion. Tr. at 127-128; I.G. Ex. 3.

42. Respondent has not been reinstated to Medicare or Medicaid. Jt. Stip. at 5.

43. This proceeding is governed by section 1128A of the Act (the Civil Monetary Penalties Law (CMPL)), and the regulations at 42 C.F.R. Part 1003 and 42 C.F.R. Part 1005.

44. Any person violating section 1128A of the Act is subject to the imposition of a civil monetary penalty of up to $2000 for each item or service claimed, an assessment of not more than twice the amount claimed for each item or service, and a period of exclusion. 42 C.F.R. §§ 1003.103, 1003.104, 1003.105.

45. Section 1128A(a)(1)(D) of the Act authorizes the Secretary of the Department of Health and Human Services (Secretary), through her delegate the I.G., to impose a civil monetary penalty, assessment, and a period of exclusion against any person who presents or causes to be presented to a State agency (such as Medi-Cal) a claim for a medical or other item or service furnished during a period in which the person was excluded from the program under which the claim was made pursuant to a determination by the Secretary under, among other sections, section 1128 of the Act. Act, sections 1128A(a)(1)(D), 1128A(i)(1); 42 C.F.R. § 1003.102(a)(3).

46. Under section 1128(a) of the Act, the Secretary (through her delegate the I.G.) excludes individuals and entities from any program under Title XVIII of the Act and directs that such individuals and entities be excluded from participation in any State health care program. Act, section 1128(a).

47. Title XVIII of the Act pertains solely to health insurance for the aged and disabled and is commonly referred to as Medicare. Subsection (h) of section 1128 of the Act defines a "State Health Care Program" as "(1) a State plan approved under title XIX, (2) any program receiving funds under title V or from an allotment to a State under such title, or (3) any program receiving funds under title XX or from an allotment to a State under such title."

48. Under section 1128(d)(2) of the Act, the Secretary (through her delegate the I.G.) is required promptly to notify each appropriate State agency administrating or supervising the administration of each State health care program of the period for which the State agency is directed to exclude the individual or entity from participation in the State health care program. Act, section 1128(d)(2).

49. Under section 1128(d)(3) of the Act, the period of exclusion under the State health care program shall be the same as the period of the exclusion under Title XVIII (Medicare), except where the Secretary grants a waiver of the exclusion. Act, section 1128(d)(3).

50. The current regulation implementing exclusions from Medicare and Medicaid states that the "OIG [Office of Inspector General] will exclude the individual or entity from the Medicare program and direct each State agency administering a State health care program to exclude the individual or entity for the same period." 42 C.F.R. § 1001.1901(a).

51. The current regulation implementing the manner in which notice of I.G.-imposed exclusions are provided to State agencies states that prompt notice will be given to "each appropriate State agency administering or supervising the administration of each State health care program of: (a) The facts and circumstances of each exclusion, and (b) The period for which the State agency is being directed to exclude the individual or entity." 42 C.F.R. § 1001.2004.

52. The regulations that were in effect in 1988 state: (1) that the OIG "will suspend from participation in Medicare," "will also require the State Medicaid agency to suspend," and will notify the "State Medicaid agencies, in order that they can promptly suspend . . . from participation in the Medicaid program" individuals and entities convicted of program-related crimes; and (2) that "suspension under Medicaid must be effective on the date established by the OIG for suspension under Medicare, and must be for the same period as the Medicare suspension." 42 C.F.R. §§ 1001.122(a) and (c), 1001.124(a)(2), 1002.211(a).

53. An extensive review of the legislative history behind sections 1128 and 1128A of the Act, convinces me that neither section 1128 nor section 1128A provide authority for the I.G. to directly exclude an individual or entity from participation in a State health care

program. See S. Rep. No. 109, 100th Cong., 1st Sess. 1 (1987), reprinted in 1987 U.S.C.C.A.N. 682.

54. Both at present and in 1988 when Respondent was excluded, the Act and the regulations authorized the I.G. to exclude providers from Medicare and to direct the appropriate State agencies to exclude such providers from their State health care programs (Medicaid). The length and duration of the State's exclusion is to correspond to the period which the I.G. imposed for the provider's Medicare exclusion.

55. The mechanism used by the I.G. to inform State agencies administering or supervising the administration of Medicaid programs of the I.G.'s Medicare exclusions is for the I.G.: (1) to send letters to State agencies where the I.G. has knowledge of the excluded provider(s) participation in a particular State's Medicaid program and (2) to send to all State agencies the CSR listing providers excluded by the I.G., and to send as well monthly lists of excluded providers. Tr. 132; I.G. Exs. 2, 3, 16.

56. To sanction a provider under section 1128A of the Act, the I.G. must prove by a preponderance of the evidence that the provider is: 1) liable under section 1128A of the Act and its implementing regulations; and 2) that circumstances exist which justify the penalty, assessment, and period of exclusion imposed and directed against that provider. The provider must prove by a preponderance of the evidence any mitigating circumstances justifying a reduction of the penalty, assessment, and exclusion. 42 C.F.R. § 1005.15(b).

57. Since Respondent was not suspended from Medi-Cal until after she submitted the claims at issue in this proceeding, the I.G. lacks authority under section 1128A(a)(1)(D) to impose any penalty, assessment, or period of exclusion against her based on the submission of the claims at issue. None of the claims were submitted during a period of time in which Respondent was excluded from Medi-Cal, the program to which the claims were made.

ANALYSIS

By letter of May 18, 1988, the I.G. notified Respondent that she was to be excluded from Medicare and the State health care programs enumerated in section 1128(h) of the Act (hereafter referred to as Medicaid) for 10 years, based on her Medicaid fraud conviction in Louisiana. The

I.G. notified Respondent further that, if she submitted claims to Medicare or Medicaid during the period of her exclusion, she would be liable for a civil monetary penalty and an assessment. Approximately two years later, Respondent submitted an application for a Medi-Cal provider number, received the provider number, and submitted claims under that number to Medi-Cal. Based on these Medi-Cal claims, the I.G. has proposed levying against Respondent penalties, an assessment, and a period of exclusion additional to that which the I.G. imposed and directed against Respondent in 1988.

Respondent does not dispute that claims were submitted to Medi-Cal under her Medi-Cal provider number during a time period in which she was excluded from Medicare. Instead, Respondent argues that, although she may have been excluded from Medicare when the claims were submitted, she was not excluded from Medi-Cal until November 28, 1990, several months after the claims in question were submitted. Respondent asserts that Medi-Cal thus was obligated to reimburse her based on those claims and, as a result, the I.G. does not have a basis upon which to exclude her. In the alternative, Respondent argues that, even if I find liability in her case, the substantial penalties, assessment, and additional period of exclusion proposed by the I.G. are not justified.

The I.G. has not based her CMPL action on any Medicare claims. Instead, The I.G. asserts that her proposed sanctions are based on the claims submitted by Respondent to Medi-Cal during what the I.G. asserts is Respondent's 10-year nationwide exclusion from Medicare and Medicaid. In essence, the I.G. is arguing that the May 18, 1988 notice letter effectuated both an exclusion from Medicare and an exclusion from all State Medicaid programs. The I.G. contends that such authority arises from one of the obvious congressional purposes for enacting Medicare and Medicaid sanctions. This congressional purpose is to ensure that providers sanctioned in one State not be allowed to evade the sanction by moving to another State.

Initially, I was impressed by the logic of the I.G.'s argument, and I construed the Act and the regulations in a manner that would permit imposition of penalties, an assessment, and a period of exclusion against Respondent even though Medi-Cal, the State agency responsible for administering the Medicaid program in California, did not suspend Respondent until after she submitted the claims at issue. See my September 16, 1994 Ruling. However, after receiving testimony from a Medi-Cal official at the hearing, and having the benefit of further briefing, I now conclude that, due to the combined failures of the

I.G. and Medi-Cal to carry out their statutory and regulatory responsibilities satisfactorily, the I.G. has no legal authority to impose sanctions against Respondent based on the claims at issue.

When I issued my Ruling, it was evident to me from the legislative history, the Act, and the regulations, that Congress did not want providers to escape the effect of an exclusion by moving to a different State and receiving a Medicaid provider number in that State. It was evident to me also that Congress intended that exclusions from Medicare and Medicaid be for the same duration. My view of the intent of Congress has not changed. Congress intended that individuals such as Respondent, who submit claims to a State Medicaid program during a period in which they are excluded from Medicare, should be sanctioned under the CMPL. Congress created a mechanism to ensure the accomplishment of its purpose. The I.G. is given the authority to exclude providers from Medicare. With regard to Medicaid, however, the I.G.'s responsibility is to notify the appropriate State agencies so that the State agencies, not the I.G., can promptly exclude any provider or prospective provider for the same period as the provider's Medicare exclusion. Accomplishing such Medicaid exclusions is not unduly burdensome, but it does require coordinated federal and State action, and that both the I.G. and the State must meet their respective responsibilities.

In this case, the mechanism set forth in the Act and the regulations required the I.G. to direct Medi-Cal to exclude Respondent from Medi-Cal for the same period that Respondent was excluded from Medicare. The mechanism set forth in the Act and the regulations then required Medi-Cal to suspend Respondent for the same period of time Respondent was excluded from Medicare. The State could have accomplished this either by not issuing Respondent a Medi-Cal provider number initially or, upon being notified of Respondent's Medicare exclusion, by retroactively excluding Respondent beginning with the effective date of her Medicare exclusion.

With regard to the I.G.'s duty to notify the States of actions taken by the I.G. to exclude providers, the Act and the regulations have consistently placed on the Secretary (through her delegate the I.G.) the responsibility for notifying the States of Medicare exclusions and, in turn, have placed on the States the responsibility for excluding providers excluded from Medicare from their Medicaid programs. In 1988, when, based on her Medicaid fraud conviction in Louisiana, Respondent was first excluded from Medicare, the Act and

the regulations imposed upon the Secretary (through her delegate the I.G.), the responsibility to notify State Medicaid agencies of her Medicare exclusion. The I.G. was to notify the State Medicaid agencies of the exclusion precisely so that the State Medicaid agencies could take their own action to exclude Respondent from State Medicaid programs. The term of any State Medicaid exclusion was to run concurrently with term of Respondent's Medicare exclusion. Also, current regulations provide that the I.G. is to direct State agencies to exclude a provider for the same period as the provider's Medicare exclusion.

The record indicates that the specific means which the I.G. employs to notify a State agency to take action to exclude a provider (for a State in which she knows a provider she has excluded from Medicare is practicing), is for the I.G. to send the State a letter directing the State to exclude the provider. In this case, the I.G. specifically notified Louisiana of Respondent's Medicare exclusion by letter in 1988, and specifically notified California by letter in 1990. For States in which the I.G. is not aware a provider excluded from Medicare is practicing, the record indicates that notification by the I.G. to State agencies of Medicare exclusions appears to take place via the CSR[4] and via monthly reports provided to State agencies detailing the names of recently excluded providers.

The I.G. asserts that the CSR does not constitute specific notice of Respondent's exclusion under the Act or the regulations. I.G. Supp. Br. at 5. In my judgment, had the I.G. provided sufficient information in the CSR (such as Respondent's social security number), the CSR might well constitute specific notice. However, for a State in which a provider is not practicing, certainly the CSR is detailed enough such that a cursory examination should alert a State Medicaid agency to investigate potential provider applicants whose name and credentials match those set forth in the CSR (or in the monthly report). If a State Medicaid agency does not attempt even such a cursory examination, the

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[4] The record does not reflect how often the CSR is updated or distributed. The record reflects only that a CSR was issued as of October 31, 1988 (I.G. Ex. 16) and that a smaller monthly list of excluded providers is issued. Tr. 132. I note that I.G. Ex. 16, the CSR reflecting sanctions through October 31, 1988, contains the names of providers sanctioned initially several years before that date.

congressional purpose is defeated and providers excluded from Medicare may receive from State Medicaid programs provider numbers to which they are not entitled.[5]

In Respondent's case, the I.G. did not notify Medi-Cal of Respondent's Medicare exclusion by specific letter until after Respondent had received a Medi-Cal provider number and begun billing Medi-Cal. Had the I.G. notified Medi-Cal specifically by letter in 1988 that Respondent had been excluded by Medicare, arguably Medi-Cal would have been informed that it should not issue Respondent a Medi-Cal provider number if she applied for one. However, the I.G. need not send a letter to every State in which a provider might, at some future date, apply for a Medicaid provider number in order to meet its notice requirements under the Act (although the I.G. could choose to do so). Sufficient notice can be provided by sending States monthly lists of excluded Medicare providers with periodic distribution of updated lists of all excluded providers as of a given date.

Here, Respondent's name has been in the CSR since 1988. Medi-Cal was responsible for reviewing Respondent's provider application to ensure that Respondent was an eligible provider. Had Medi-Cal done even a cursory investigation, Medi-Cal might not have erred and issued Respondent a Medi-Cal provider number until Medi-Cal checked that she was not the Jesusa N. Romero, M.D. listed in the CSR.[6] Moreover, since Medicare and Medicaid exclusions are to be coterminous, Medi-Cal erred in not excluding Respondent as of the effective date of

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[5] The congressional purpose will be defeated also where a State, even upon receiving specific notice of a Medicare exclusion, suspends a provider as of the date of the State's letter of suspension rather than as of the effective date of the Medicare exclusion.

[6] While Medi-Cal may have been concerned with the harm which might accrue to a potential provider if the approval of a provider number was delayed erroneously by such investigation, a potential provider should not be harmed by such investigation. This is because Medi-Cal will reimburse a provider up to one year prior to receiving a provider number for services provided to Medi-Cal recipients during that year. Further, Medi-Cal's greater concern should be allowing potentially untrustworthy providers to receive provider numbers where an applicant for a provider number may have been excluded from Medicare or Medicaid.

her 1988 Medicare exclusion. Perhaps Medi-Cal could have avoided this situation when it received the I.G.'s letter in 1990 notifying Medi-Cal of Respondent's 1988 Medicare exclusion. Medi-Cal might have notified Respondent then that she was retroactively excluded from Medi-Cal as of 1988, not November 28, 1990. However, Medi-Cal did not take this action.[7] Instead, Medi-Cal excluded Respondent as of November 28, 1990, after the claims at issue were submitted.[8] As a result of this inadvertence, Respondent was able to receive and bill under a provider number to which she was not entitled.

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[7] At this time, I make no finding as to whether the I.G. might bring a CMPL action against Respondent, based on the claims at issue, if Medi-Cal retroactively modifies Respondent's Medi-Cal exclusion to commence as of the effective date of her Medicare exclusion. As of the time of her exclusion from Medicaid in Louisiana (June 7, 1988), Respondent was on notice that she would be excluded from all State health care programs (Medicaid) upon separate action taken directly by a State. Moreover, Respondent was on notice that she would be acting at her own risk if she became a State Medicaid program provider subsequent to the I.G.'s notice letter and prior to a State suspending her from its Medicaid program, since the State would be compelled by law to suspend her for the same period as the period of her Medicare exclusion. At the hearing, the Medi-Cal official who testified was confused initially over the effective date of Respondent's Medi-Cal suspension date, testifying that it commenced as of the effective date of Respondent's Medicare exclusion. Tr. at 120. Under questioning by Respondent's counsel, the Medi-Cal official confirmed that Respondent was suspended after the claims at issue were submitted. Tr. at 122-124. The Medi-Cal official provided no explanation for the selection of this date. The record does not reflect that the I.G. has made any effort to require Medi-Cal to conform its suspension of Respondent to the same period as Respondent's Medicare exclusion.

[8] I note that Medi-Cal has changed its provider application to ask whether or not an applicant has been excluded from Medicare or Medi-Cal. However, this question does not obviate the need for the investigation by Medi-Cal of a provider applicant. An applicant might lie about whether or not they were excluded. If so, and if Medi-Cal does not exclude the individual from Medi-Cal until after the individual has received a provider number and claims have been made, there might still be no basis to sanction the individual under the CMPL.

I recognize that Respondent bears significant responsibility for allowing this situation to occur. Respondent is not a naive individual. Respondent is a practicing physician with many years of experience in program billing. Moreover, Respondent is well aware of the pitfalls of program billing, having been convicted of Medicaid fraud based on her billing practices. Respondent has testified that she knew that she was excluded from Medicare and from State health care programs. Tr. at 169, 178-179, 199-201, 207-208. When she began her practice in California, Respondent testified that she was careful not to bill Medi-Cal, due to her fear of committing a billing offense. Tr. at 171, 201. Respondent testified that she was careful also to inform two California hospitals she worked for that she had been excluded. Tr. at 201-202. Given Respondent's professional status and personal history, I do not find to be credible her assertion that she did not know Medi-Cal was a Medicaid program and, thus, a State health care program within the ambit of her exclusion. Before applying for a Medi-Cal provider number, Respondent should have thoroughly investigated (either by directly contacting Medi-Cal and asking or by consulting with an attorney in California) whether her State health care program exclusion encompassed Medi-Cal. Respondent abdicated this responsibility. Her applying for a Medi-Cal provider number and her subsequent billing for services she rendered to Medi-Cal patients are especially egregious acts.

However, in this instance, the Medi-Cal claims at issue are not a basis to sanction her under the CMPL.[9] Here, the trigger for sanctioning Respondent under the CMPL is that Respondent must have submitted the claims at issue to Medi-Cal during a period in which she was excluded by Medi-Cal. The evidence in this case proves, however, that, during the time period in which Respondent submitted the claims at issue, Respondent was not excluded from Medi-Cal.

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[9] I make no finding as to whether Respondent can be sanctioned for her conduct under State law or pursuant to another federal statute or regulation. Respondent may have failed to advise Medi-Cal that she was previously excluded from Medicare and the Medicaid program in the State of Louisiana. However, even if this were the case, such failure does not alter the fact that Medi-Cal did not exclude Respondent from its program until after she submitted the claims at issue here. That exclusion must occur in order for there to be a legal basis for the I.G.'s action.

CONCLUSION

For there to be a basis for the I.G. to sanction Respondent in this case, Respondent must have submitted the claims at issue to Medi-Cal during a period in which she was excluded from Medi-Cal. Respondent, however, was not excluded from Medi-Cal when the claims at issue were submitted. Thus, the I.G. has no authority to impose the penalties, assessment, or exclusion proposed in her Notice.

/s/

Edward D. Steinman
Administrative Law Judge