Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Michael D. Dinkel
Docket No. A-11-108
Decision No. 2445
March 14, 2012

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Michael D. Dinkel (Petitioner) appeals the July 12, 2011 decision of Administrative Law Judge (ALJ) Steven T. Kessel sustaining the Inspector General's (I.G.'s) exclusion of Petitioner from participating in Medicare, Medicaid, and all other federal health care programs for eight years. *Michael D. Dinkel,* DAB CR2396 (2011) (ALJ Decision).

The I.G. excluded Petitioner pursuant to section 1128(b)(7) of the Social Security Act (Act) permitting exclusion of individuals who have committed an act described in section 1128A of the Act.[1] Section 1128A(a)(1)(A) and (B) authorizes the I.G. to exclude an 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.

Petitioner was sole owner and President of Drew Medical, Inc. (Drew), a corporation that performed diagnostic imaging services. Between 2000 and 2006, Drew submitted thousands of claims to Medicare and Medicaid seeking reimbursement of more than $1.6 million for performing contrast injection procedures for venographies, a diagnostic test that Drew admittedly did not perform. Drew made these claims in conjunction with Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans that it performed that involved the use of contrast material.

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[1] The current version of the Act is available at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm. On this website, each section of the Act contains a reference to the corresponding chapter and section in the United States Code.

In a partial summary judgment, the ALJ concluded that the undisputed facts established that Petitioner caused Drew to present the claims at issue and that the claims were false, fraudulent or not provided as claimed. After then conducting a hearing, the ALJ found that Petitioner should have known that Drew could not permissibly claim reimbursement under a venography injection contrast code for using contrast in providing MRIs and CT scans and that Petitioner acted in reckless disregard of the falsity of the claims. The ALJ also concluded that an eight-year exclusion was reasonable under the circumstances.

Petitioner does not contend that Drew properly presented the claims at issue here to Medicare and Medicaid or that the services were provided as claimed or were not false. Rather, Petitioner argues that the ALJ erred in finding that he was culpable because he should have known that the items or services were not provided as claimed or that the claims were false. In the alternative, Petitioner argues that an exclusion of eight years is not reasonable.

For the reasons discussed below, we uphold the ALJ Decision.

Standard of Review

The standard of review on a disputed factual issue is whether the initial decision is supported by substantial evidence on the whole record. The standard of review on a disputed issue of law is whether the initial decision is erroneous. 42 C.F.R. § 1005.21(h).

The ALJ resolved two issues in the case by summary judgment. Whether summary judgment is appropriate is a legal issue that we address de novo. *Kim J. Rayborn,* DAB No. 2248 (2009); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004).

Relevant Legal Authority

Section 1128(b)(7) provides as follows:

> (b) Permissive Exclusion. The Secretary may exclude the following individuals and entities from participation in any Federal health care program . . . .
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> * * *
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>> (7) Fraud, kickbacks, and other prohibited activities. Any individual or entity that the Secretary determines has committed an act which is described in section 1128A . . . .

For this exclusion, the I.G. relied on section 1128A(a)(1)(A) and (B), which provides that any person who --

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency . . ., a claim . . . that the Secretary determines—

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed . . . [or],

(B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent . . . .

Section 1128A(i)(7) defines the term "should know" to refer to any person who --

with respect to information—

(A) acts in deliberate ignorance of the truth or falsity of the information; or
(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

Summary of ALJ Decision[2]

This case involves claims under "CPT" code 36005. "CPT" stands for "current procedural terminology" and CPT codes provide "standardized shorthand methodology for particularizing the items or services that a provider may claim for reimbursement." ALJ Decision at 2. In filing a claim for reimbursement under Medicare or Medicaid, the provider "identifies the CPT code that most accurately represents the item or service that it has provided" and is reimbursed "a predetermined amount" based on the CPT code claimed. *Id.* at 2-3.

Since 2001, the CPT Manual has defined CPT code 36005 as an "[i]njection procedure for extremity venography (including introduction of a needle or intracatheter)."[3] ALJ Decision at 3; P. Ex. 19, at 3. As described by the I.G. in its letter proposing to exclude Petitioner –

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[2] This summary derives from the ALJ Decision and the record. It is intended to provide context for our discussion and not to constitute new findings of fact.

[3] Between 1999 and 2001, the CPT Manual described code 36005 as covering an "[i]njection procedure for contrast venography (including introduction of needle or intracatheter)." ALJ Decision at 3. At all relevant times, CPT 36005 expressly referenced venography procedures. The term venography refers to the procedure of making the images of a vein; the term venogram refers to the images made in the process. I.G. Ex. 64, at 72.

> Venography is a specialized invasive diagnostic procedure that involves the injection of contrast material into a specific vein, followed by a series of x-rays that allow the diagnostician to identify abnormalities, such as a blood clot, in the target vein. See CPT Manual, 2002-2006; THE GALE ENCYCLOPEDIA OF MEDICINE 3492-3493 (2nd ed. 2002).

I.G. Ex. 1, at 3.

It is undisputed that during the period at issue, Drew never performed venographies. Beginning in January 2000, Drew routinely billed CPT code 36005 **in addition to** the applicable CPT code for the contrast MRI or CT scan that it actually performed. *Id.* at 3; 9. Over the following six-year period, Drew submitted a total of 8,853 claims to Medicare and 638 claims to Florida Medicaid under CPT code 36005, causing those programs to pay Drew $1,676,777.90. *Id.* at 3, 5, Atts. A, B, C, D. The claims between November 6, 2003 and May 1, 2006, which are within the six-year statute of limitations set forth in section 1128A(c)(1), provide a basis for this exclusion. Those claims numbered 4,492 for Medicare and 298 for Medicaid.[4] I.G. Ex. 1, at 1, 4-5; I.G. Ex. 55. Drew's billing systems administrators programmed its automated billing system to bill CPT code 36005 with every MRI or CT scan that Drew performed that used contrast material. ALJ Decision at 11-12.

Based on hearing testimony and other evidence in the record, the ALJ determined that Petitioner should have known that the claims at issue were false. Specifically, the ALJ found that a reasonable provider should have known from the "obvious language" in the CPT Manual for CPT code 36005 and the CPT Manual guidelines for radiology (Part 70000) that billing under CPT code 36005 in conjunction with MRIs and CT scans was improper, or, at a minimum, a reasonable provider should have known that he needed to consult an authoritative source before concluding that billing under CPT code 36005 was proper. ALJ Decision at 6-7. The ALJ also found that Petitioner did not conduct any systematic reviews of billing prior to 2006 and that he failed to act on concerns and warnings expressed by multiple staff members at least by 2003 and 2004 that should have alerted him to the impropriety of using CPT code 36005. *Id.* at 8-12. In making these findings, the ALJ rejected a number of Petitioner's factual allegations about the circumstances surrounding Drew's continued use of the code.

The ALJ concluded that an exclusion of eight years was reasonable.

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[4] We note that the ALJ mistakenly refers to the larger number of claims as having been submitted over 2003 to 2006 period. *See, e.g.,* ALJ Decision at 1, 2.

Analysis

1. Petitioner's claim that the ALJ applied a strict liability standard in finding an offense under section 1128A(a)(1)(A) and (B) lacks merit.

Petitioner argues that, in concluding that Petitioner had committed an offense under section 1128A(a)(1)(A) and (B), the ALJ erred by applying a strict liability standard in the face of evidence "that showed the submission of claims with the errant CPT code via an automated billing system was negligent." P. Br. at 4. In making this argument, Petitioner cites various statements from court cases decided under the False Claims Act (FCA): "a mistaken or negligent submission of a false claim is not an offense under the FCA" (P. Br. at 13, citing *Hindo v. Univ. of Health Sciences/The Chicago Med. Sch.*, 65 F.3d 608, at 613 (7th Cir. 1995)); "the Act is not designed to 'punish honest mistakes or incorrect claims submitted through mere negligence'" (P. Br. at 14, citing *States ex rel. Hefner v. Hackensack Univ. Med.*, 495 F.3d 103, at 109 (3d Cir. 2007); and "a provider acted reasonably when his claims submission was 'consistent with a reasonable interpretation of ambiguous regulatory guidance'" (P. Br. at 15, citing *U.S. v. Prabhu,* 442 F. Supp. 2d 1008, at 1029 (D. Nev. 2006)).[5] Petitioner characterizes the false claims at issue here as "a collective misjudgment by many employees within Drew" (P. Br. at 17); an "inadvertent mistake" (*id.* at 10); or "negligence at most in the review of a coding question" (*id.* at 3). Petitioner concludes that the cited cases "compel a finding in the Petitioner's favor," given the absence of anything more than mere negligence in his situation. *Id.* at 4.

Petitioner's argument is without merit. The ALJ both articulated and applied a standard based on the long-standing requirements that a provider has a duty to "understand Medicare and Medicaid billings requirements and to apply them scrupulously to the claims" presented for payment. ALJ Decision at 5. He proceeded to analyze whether Petitioner took reasonable steps to comply with that duty when information became available to him that called into question whether Drew was presenting improper claims for payment.

The only basis for Petitioner's claim that the ALJ applied a strict liability standard is Petitioner's argument that his version of the facts (*i.e.*, that he was negligent), as opposed to the facts found by the ALJ, compels a finding in his favor under applicable Board and case law. As discussed below, the ALJ's material factual findings are supported by substantial evidence in the record as a whole and show that this was not "a mistaken or

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[5] Cases decided under the FCA may be useful in applying section 1128A(b)(7) because the FCA's definition of the "knowing" and "knowingly" is the same as section 1128A's definition of "knows or should know." We conclude, however, that the ALJ applied a standard consistent with that articulated in the cited cases.

negligent submission of a false claim" (*compare Hindo* at 613, *with* ALJ Decision at 13-14); that the claims did not result from "honest mistakes" (*compare Hefner* at 109, *with* ALJ Decision at 5); and that the claims were not "consistent with a reasonable interpretation of ambiguous regulatory guidance" (*compare Prabhu* at 1029, *with* ALJ Decision at 6-8).

Therefore, the cases cited by Petitioner in fact support a conclusion that the ALJ's determination that Petitioner should have known the claims were false and violated section 1128A(a)(1) was consistent with the reasonable provider standard articulated by Petitioner and with prior caselaw.

2. The facts found by the ALJ support the legal conclusion that Petitioner's conduct satisfied the "should know" requirement of section 1128A(a).

The ALJ determined that "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."[6] ALJ Decision at 4 (emphasis added). Under section 1128A(h)(7), the term "should know" means that a person has acted in "deliberate ignorance of the truth or falsity" or "in reckless disregard of the truth or falsity" of information. In coming to the conclusion that Petitioner should have known that the claims at issue were false, the ALJ relied on the following evidence and reasoning.

The ALJ found that "Petitioner had a duty, as sole owner and President of Drew, to understand Medicare and Medicaid billing requirements, such as the relevant CPT provisions, and to apply them scrupulously to the claims that he caused to be presented." ALJ Decision at 5, citing *Cary Frounfelter and Kast Orthotics and Prosthetics, Inc.*, DAB CR1808 (2008), *aff'd*, DAB No. 2211 (2008). The ALJ pointed out that Petitioner agrees that he had a duty to understand and scrupulously apply billing requirements.[7]

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[6] We reject Petitioner's argument that the ALJ's granting partial summary judgment that Petitioner caused the submission of false claims somehow "rendered the purpose and approach of the requested hearing legally ambiguous and improperly structured." P. Br. at 4. Petitioner does not identify any disputes of fact about his responsibility for the company's presenting the claims or about the falsity of claims. The ALJ reserved for hearing whether Petitioner "should have known" the claims were false - about which there were significant factual disputes. As to this issue, Petitioner had every opportunity to argue and present any evidence for his contention that "the submission of claims with the errant CPT code via an automated billing system was negligent" and did not meet the scienter requirement of section 1128A(a)(1)(A) and (B). *Id.*

[7] Petitioner objects to the ALJ's use of his statements regarding his understanding of his responsibility. He argues that while he "acknowledged that he [was] responsible for the operations of the company and has a duty to investigate billing issues and to be familiar with regulations applicable to billing federal health care programs," the ALJ "selectively quot[ed]" his testimony as if he was making "a legal admission of recklessness." P. Br. at 6, citing ALJ Decision at 5-6. We disagree. As discussed in this decision, the ALJ chronicled and relied on the evidence in the record that establishes Petitioner acted recklessly in approving continued use of CPT code 36005. The ALJ did not attribute to Petitioner an admission that he recklessly failed in his duty, but rather properly considered Petitioner's acknowledged awareness of the extent of that duty as a relevant fact.

ALJ Decision at 5-6, *citing* ALJ Hearing Transcript (Hrg. Tr.) at 138; 145. Moreover, Petitioner acknowledges that, when a question was brought to him about Drew's use of CPT code 36005, he had a duty to make a "reasonable inquiry" about that use. Board Oral Argument Transcript (OA Tr.) at 44.

Furthermore, the ALJ found that, in reviewing Drew's use of CPT code 36005 in 2004, Petitioner "failed to discharge that duty" and that "[h]is failure constituted reckless indifference to the propriety of the claims he caused to be presented." ALJ Decision at 6.

In reaching this conclusion, the ALJ looked in part to the CPT Manual definition for CPT code 36005 as an "[i]njection procedure for extremity venography (including introduction of a needle or intracatheter)." The ALJ reasoned that the facts that: (1) the definition stated that the injection was for "extremity venography" and (2) venography is "a diagnostic procedure that is totally different from MRIs and CT scans and a procedure that Drew never performed" would have caused a reasonable provider "experienced in the performance of CT scans and MRIs" to understand that the code was unrelated to these MRIs and CT scans. ALJ Decision at 7. Alternatively, at a minimum, this "obvious language" should have caused Petitioner to investigate further the meaning of "extremity venography." *Id.* at 6-7. The ALJ found that it was "inconceivable that Petitioner would have failed to understand that distinction [between venography and CT scans and MRIs] <u>had he made an effort</u> to comprehend CPT code 36005." *Id.* at 7 (emphasis added).

Additionally, the ALJ found that, in determining whether a separate contrast injection code could be billed with MRIs and CT scans, Petitioner acted recklessly by ignoring the guidelines to Part 70000 of the CPT Manual related to the administration of contrast for MRIs and CT scans. *Id.* at 6, citing Hrg. Tr. at 120. Part 70000 contains the provisions relating to radiology services, including the MRIs and CT scans "that were actually performed by Drew." *Id.* The ALJ quoted the following text from the section of the introductory radiology guidelines titled "Administration of Contrast Material(s)":

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

Id. at 7, citing I.G. Ex. 14, at 5 (*see* Part 6a) (emphasis added). The ALJ concluded that these guidelines make it "obvious" that CPT code 36005 cannot be added on "as a means of capturing the administration of contrast material to a beneficiary receiving an MRI or a

CT scan" because "[t]he radiology codes that covered [MRIs and CT scans] were global in the sense that they did not allow for separate claims for administration of contrast material."[8] *Id.* (emphasis added).[9]

The ALJ rejected Petitioner's testimony that he was reasonably misled by "ambiguity" in the CPT Manual into believing that Drew could bill under CPT code 36005. ALJ Decision at 7, citing Hrg. Tr. at 117-18, 144-45. The ALJ noted that, had Petitioner actually believed in 2004 that the CPT Manual presented any ambiguity, he was obligated to investigate further and could not simply "take advantage of any perceived ambiguities in the CPT to file Medicare claims as he saw fit." *Id.* Noting that no evidence showed that Petitioner expressed contemporaneous concern about ambiguities or instructed his staff to research the issue in 2004, the ALJ observed that Petitioner had not acted like someone who was "baffled" or "who struggled to obtain a clear understanding" of the CPT Manual. ALJ Decision at 7. Finally, the ALJ found that Petitioner was informed of and recklessly disregarded concerns expressed by his staff (discussed below) about the improper use of CPT code 36005. ALJ Decision at 9-11, and record citations therein.

We conclude that this evidence and the inferences which the ALJ reasonably drew demonstrate that Petitioner acted in reckless disregard or willful ignorance of the false claims he submitted. We turn next to Petitioner's claims that other evidence in the record as a whole, ignored or discounted by the ALJ, undercuts the existence of substantial evidence to support the ALJ's findings or demonstrates the unreasonableness of inferences drawn by the ALJ.

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[8] As discussed subsequently, it is not disputed that Drew also billed MRIs and CT scans performed with oral contrast (as opposed to injected contrast) under contrast CPT codes. The second paragraph of the quoted language appears to raise a question about whether this billing was proper. The I.G. did not raise this issue, however, so we do not address it further.

[9] The ALJ's conclusion that the Part 70000 guidelines clearly inform providers that a contrast injection code could not be billed in addition to the applicable MRI or CT scan code is supported by the I.G. expert's testimony. He testified that the CPT Manual provides separate codes for MRIs and CT scans according to body part and then, "for non-contrast examinations, contrast–enhanced examinations, and examinations performed both before and during or after the administration of contrast."[9] I.G. Ex. 17, at 4. He explained further that, for MRIs and CT scans, "contrast-enhanced codes are generally assigned higher values [i.e., reimbursement] than their counterpart non-contrast codes" to compensate for the extra work and costs involved. *Id.* at 5. He also testified that "reporting additional CPT codes to report contrast injections for such contrast enhanced CT or MR services amounts to 'double dipping' and is not appropriate." *Id.* Citing the language relied on by the ALJ, the I.G. expert witness concluded that "in the radiology guidelines section of CPT, this concept has been explicitly codified." *Id.*

3. Petitioner's arguments that the ALJ's factual findings are not supported by substantial evidence in the record and that the inferences the ALJ drew from them are unreasonable are without merit.

On appeal, Petitioner challenges a number of the findings and inferences underlying the ALJ's conclusion that Petitioner should have known these claims were false. We discuss first Petitioner's overarching attacks on the ALJ's credibility determinations. We then explain why Petitioner's other arguments about the ALJ's findings, inferences, and rejection of evidence on which Petitioner relies are without merit.

a. We find no reason to disturb the ALJ's credibility determinations.

The ALJ found that testimony given by Petitioner, and by two Drew employees, Andrea Shelton and Charles Marrero, lacked credibility.[10] ALJ Decision at 10-12. Much of Petitioner's legal argument rests on his insistence that the version of events put forth in that testimony should have been accepted as truthful. We discuss later the specific factual claims which the ALJ rejected, but here we address the overall contention that the ALJ articulated no basis to find the testimony relied on by Petitioner less than credible.

Petitioner and Mr. Marrero testified at the in-person hearing; Ms. Shelton did not. Petitioner asserts that the ALJ wrongly "rejects Petitioner's explanation of the billing issue and also finds billing supervisor Andrea Shelton lacks credibility for no explained reason." P. Br. at 20. As to his and Ms. Shelton's testimony, he asserts that "several employees support Petitioner's version, not just Ms. Shelton, and [t]here are no material inconsistencies in her testimony via affidavit or deposition and certainly none are cited in the ALJ Decision to support the finding she was not credible." *Id.*

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[10] Mr. Marrero initially programmed Drew's automated system to bill CPT code 36005 with contrast-enhanced MRIs or CT scans. P. Ex. 9, at ¶ 10. The ALJ did not believe Mr. Marrero's testimony that he was told by a representative of a Medicare carrier that CPT code 36005 could be billed with MRIs and CT scans. ALJ Decision at 12. The ALJ also concluded that this testimony was, in any event, irrelevant because Mr. Marrero "never communicated to Petitioner any of the information that he allegedly obtained from [the representative] so Petitioner "cannot now claim to have relied on something that never was told to him." *Id.* On appeal, Petitioner also agrees that Mr. Marrero's testimony about his conversations with the representative is irrelevant to Petitioner's liability. *See, e.g.* , P. Posthearing Br. at 11; P. Br. at 11-12. Therefore, we do not address this credibility determination because other evidence is more than sufficient to support the ALJ's findings and conclusions as to Petitioner's exclusion.

We also note that Petitioner objects to the ALJ's exclusion of its Exhibit 18, a declaration clarifying that a Dr. Dorn's and Mr. Marrero's employment tenures at Drew overlapped. P. Br. at 22. Mr. Marrero testified that a conversation with Dr. Dorn, a radiologist, led him to believe CPT code 36005 could permissibly be billed with contrast-enhanced MRIs and CT scans. P. Ex. 9, at ¶ 7. Any error in excluding this exhibit was harmless since the ALJ did not ultimately rely on the state of Mr. Marrero's knowledge in concluding that Petitioner should have known these claims were false. Moreover, we note that Mr. Marrero's representations as to the fact and import of his alleged conversation with Dr. Dorn are contradicted by Dr. Dorn's statements to the I.G. investigator. I.G. Ex. 51, at 1 (stating "he does not recall any conversations with Marrero" and "[Dr. Dorn] knows that you can't bill separately for a contrast study, because the procedure always includes the contrast injection.").

The Board generally defers to an ALJ's findings on credibility of witness testimony unless there are compelling reasons not to do so. *Cedar Lake Nursing Home*, DAB No. 2390, at 9 (2011); *Woodland Oaks Health Care Facility*, DAB No. 2355, at 7 (2010) *Koester Pavilion*, DAB No. 1750, at 15, 21 (2000). Even where a witness has not testified in person before the ALJ, the Board has recognized that credibility determinations are appropriately made by the ALJ since credibility can involve more than simply evaluating witness "demeanor" or other behavior apparent from in-person observation. *Lifecare Center of Tullahoma*, DAB No. 2304, at 24 (2010), *citing Ginsu Products, Inc. v. Dart Industries, Inc.*, 786 F.2d 260, 263 (7th Cir. 1986) ("[F]actors other than demeanor and inflection go into the decision whether or not to believe a witness. Documents or objective evidence may contradict the witness' story; or the story itself may be so internally inconsistent or implausible on its face that a reasonable factfinder would not credit it."). Petitioner is incorrect that the ALJ gave "no explained reason" for disbelieving Petitioner's explanation of the billing issue and some of what Ms. Shelton said. P. Br. at 20. The ALJ found that Petitioner's denials of awareness of staff concerns were "self-serving and not believable." ALJ Decision at 10. A witness's self-interest is one factor that may reasonably be considered in evaluating the credibility of that witness's testimony. In that regard, the ALJ could also take into account the difference between the statements of Petitioner and Ms. Shelton, who is still employed at Drew, and those of other witnesses who left employment at Drew.

The ALJ explained, for example, that certain testimony by Ms. Shelton was "simply unbelievable" in the face of other evidence in the record, to the point that her claimed unawareness of staff concerns, if true, would prove only that "she, like Petitioner, had the ability to blind herself to what was going on around her." *Id.* at 11. The ALJ also pointed to areas in which Petitioner made multiple, shifting assertions that undermined the ALJ's belief in any of them, to areas in which corroborating evidence should have been available but was not produced, and to evidence and testimony which directly contradicted testimony proffered on behalf of Petitioner. *Id.* at 10-12.

Below, we discuss evidence relating to specific disputes of fact raised by Petitioner before the ALJ and on appeal to us. We conclude here, however, that Petitioner's general argument that the ALJ's credibility determinations were unexplained is wrong on the record and that Petitioner has not provided any compelling reason for us to overturn those credibility determinations.

b. The ALJ provided a reasoned basis, supported by substantial evidence in the record as a whole, for rejecting Petitioner's alternative version of relevant events.

Petitioner contends that the evidence in the record as a whole supports an alternative version of the relevant events (rather than the ALJ's account), which may be summarized as follows:

The misuse of CPT code 36005 resulted from "a collective misjudgment by many employees within Drew" or "one isolated misjudgment assessed in hindsight that was a collective misjudgment by many employees within Drew." P. Br. at 17. At most, Petitioner was negligent or mistaken in his actions. *Id.* at 18. Mr. Marrero set up the automated billing system to include CPT code 36005 when contrast was used based on his research and belief that this was proper. *Id.* at 22. The automated system identified the code only as "INJ CONTRAST," with no reference to venography. *Id.* at 7, 10. In 2004, Ms. Shelton, who was Manager of the Billing and Collections Department for Drew, came to Petitioner with a specific narrow question about whether CPT code 36005 should be billed when the contrast for the MRI or CT scan was administered orally, and, therefore, presumably without an injection. P. Br. at 7, 11; P. Ex. 5, at ¶ 8, 11; Hrg. Tr. at 111-12. Ms. Shelton gave Petitioner the page of the CPT Manual for CPT code 36005 to review, but he asserts that he only focused on some of the language that was highlighted for him. P. Ex. 5, at ¶ 11; Hrg. Tr. at 112-14. Petitioner asserts that "the question raised [by Ms. Shelton] on the use of CPT 36005 to *Petitioner* did not involve an identification of venograms or whether CPT 36005 was an appropriate code for venograms." P. Br. at 7, *citing* Hrg. Tr. at 111-112; P. Ex. 1 at ¶¶ 6, 10; P. Ex. 2 at 141[11]; P. Ex. 5 at ¶¶ 11-12 (emphasis in original) After meeting with Ms. Shelton and Drew's Director of Operations, Gail Meece, Petitioner determined that Drew could continue to use the code for MRIs and CT scans with orally administered contrast. P. Br. at 7, 20; P. Ex. 1, at ¶ 6; Hrg. Tr. 147-148. Petitioner asserts that he relied on the knowledge and agreement of Ms. Shelton and Ms. Meese in concluding that it was acceptable to continue claiming for CPT code 36005. P. Br. at 9, *citing* P. Ex. 5 ¶ 11-12; P. Ex. 1 at 10; P. Ex. 10 at 62-63; Hrg. Tr. at 115, 116, 127, 138. After an internal coding review in 2005, further research disclosed that the "code was mistakenly used" and Petitioner promptly discontinued its use, hired outside attorneys and auditors, and voluntarily began making repayments. P. Br. at 8, and record citations therein.

Petitioner contends that this version of the events establishes that he did not have the necessary information to discover Drew's billing error prior to 2005 and that, if he had, he would have acted quickly to fix it as he did in 2006. P. Br. at 6.

In considering the ALJ's factual findings, we note the basic rule that evaluating the weight to be given to conflicting evidence is quintessential to the role of the factfinder. *See, e.g. Golden Living Center – Frankfort,* DAB No. 2296, at 7 (2009) (stating that "the ALJ's general authority to determine the weight and significance of conflicting evidence,

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[11] There are multiple depositions in the record, including Petitioner's at Petitioner Exhibit 2. Some of the depositions, including Petitioner's, have multiple deposition pages on an exhibit page. All citations are to deposition pages, not the exhibit pages.

including expert testimony . . . is part of the essential function of the ALJ as a factfinder"). Evaluation necessarily means that some evidence will be accorded greater credit while other evidence may be rejected entirely or given less weight. *See, e.g., Emerald Oaks,* DAB No. 1800, at 16 (2001) (stating that '[e]ach piece of evidence is to be given such weight as it deserves, depending on such factors as its relevance, reliability, credibility of the source, relevant expertise and factual underpinnings of opinion testimony, and so on"). The ALJ as factfinder is expected to consider the evidence and provide a rational explanation for rejecting or assigning less weight to evidence that tends to conflict with the findings made. That the ALJ weighed and rejected Petitioner's view of the evidence does not mean that he ignored the evidence.

We will not disturb the ALJ's assignment of weight to conflicting evidence where it is reasonably explained. Therefore, while we address later the specific evidence as to the disputes of fact raised by Petitioner on appeal, we reject Petitioner's position that the ALJ was obliged to accept his version of these events.

i. Whether Petitioner was merely negligent and was only made aware of a narrow issue about whether to use CPT code 36005 when contrast was administered orally.

In finding that Petitioner was alerted by his staff to the problem with the use of CPT code 36005 by at least 2004, the ALJ relied in part on the November 2004 meeting Petitioner had with Ms. Shelton and Ms. Meece. ALJ Decision at 10. The only evidence in the record that the question at the November 2004 meeting was limited to whether CPT code 36005 could be permissibly billed for oral (as opposed to injected) contrast comes from Petitioner and Ms. Shelton. Not only does Ms. Meece not corroborate their description of a discussion of oral contrast during the meeting, she also does not corroborate their claim that she informed them at the November 2004 meeting that oral contrast involved an injection as well and justified use of CPT code 36005. I.G. Ex. 35, at 61-62. In rejecting Petitioner's characterization of the scope of the meeting, the ALJ emphasized multiple staff emails beginning in 2003 and into 2004 expressing increasing concern about the use of the code that did not, he found, "suggest that the staff's concern centered on narrow questions of whether the code could be used to claim reimbursement for oral, as opposed to injected, contrast . . . ." ALJ Decision at 10. For example, an August 4, 2004 email from Randi Terry, Drew's radiology information systems manager, addressed to Petitioner, stated:

> 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] has some documentation regarding this. After a conversation with Doug [Dinkel, Petitioner's brother], 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, cited in ALJ Decision at 9 (underscored emphasis added). The ALJ did not believe Petitioner's claim that he never read this email,[12] but, whether or not Petitioner read it, the email shows broad concern among the billing staff in August 2004 about the use of the code generally. This reading is confirmed by Ms. Terry's deposition testimony that questions about oral contrast soon broadened to general questioning of the appropriateness of using the code at all. I.G. Ex. 62, at 98. The ALJ also pointed to emails between Ms. Shelton and Ms. Terry in 2003 about their concern that "using CPT code 36005 as a routine addendum to CT scan and MRI reimbursement claims was improper." *Id.* at 10, citing I.G. Ex. 34 (October 2003 email from Ms. Shelton that she "would like someone with expertise in coding to let me know if this is a code that should be used when billing procedure codes w/contrast and w/followed by w/out"); I.G. Ex. 43 (a November 2003 email from Ms. Shelton to Ms. Terry stating "URGENT!!!!!!!!! PLEASE LET ME KNOW HOW WE CAN GET THE 36005 WHERE IT IS NOT ATTACHED ON EVERY TEST IN THE REASON MACRO FIELDS. THIS NEEDS TO BE UPDATED ASAP . . . ."); and I.G. Ex. 44 (January 2004 email from Ms. Shelton to Ms. Terry stating "Can you get a call into Medical Manager to see how we can delete 36005 off our reason macro codes."). The ALJ concluded, "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." *Id.* Ms. Shelton's own earlier deposition testimony indicates a broader concern than oral as opposed to injected contrast:

> I don't remember what the [billers'] concerns [in 2004] all together were. It was just discussed, and it really went still back to the bundling and unbundling. Should we bill for it separately or should we delete it completely from our reason macro codes, and just let the procedure go out by itself because the procedure itself is stating contrast already being injected.

[12] Petitioner testified that he did not read this email. Hrg. Tr. at 128-129, P. Ex. 1 at ¶ 7; P. Ex. 2, at 87. In support of this testimony, Petitioner relied on I.G. Exhibit. 30, which is a copy of the email with entries at the bottom reflecting confirmation of "Delivery " to "Administration," Petitioner, and four other employees but confirmation of "Read" only by the names of the four employees. The ALJ found the "shifting nature of [Petitioner's] explanations [for why he did not read the email] undermines the credibility of all of them." ALJ Decision at 11. The ALJ finding is supported by Ms. Terry's deposition testimony stating that her conversations with Petitioner after the email led her to believe he had received it, knew what she was talking about, and had received the research referred to in the email. I.G. Ex. 62, at 180-186.

I.G. Ex. 12, at 235 (emphasis added).

The ALJ's inference that Petitioner could not have been unaware of such strong and widespread concerns is reasonable.

Furthermore, the ALJ could reasonably conclude that, regardless of how narrow a question Ms. Shelton posed in November 2004, Petitioner was confronted with a concern about whether a contrast injection code could be permissibly billed in conjunction with some MRIs and CT scans and was shown the coding manual excerpt. After that, for Petitioner to ignore the content of the excerpt provided and fail to review the guidelines for billing the services he did provide went well beyond mere negligence. ALJ Decision at 6-7. The page from the CPT Manual that Petitioner was shown defined CPT code 36005 as "Injection procedure for extremity venography (including introduction of a needle or intracatheter)." Petitioner testified variously that he read the definition in conjunction with the meeting (P. Ex. 2, at 223) or that he "may have" or "probably" read it (Hrg. Tr. at 113-114) or that he did not know what venography meant (*id.* at 151). Yet, Petitioner did not seek information from his staff, from his radiologists, or from Medicare officials to determine what venography was or how a code related to venography could be appropriately be used for the services Petitioner provided. As the ALJ concluded, this was not the conduct of a person who had any interest in determining whether a code was properly being billed by his company. ALJ Decision at 7.

The ALJ reasonably rejected Petitioner's strained explanations for continuing to use the code. ALJ Decision at 10. For example, Petitioner claims to have read general statements about "Vascular Injection Procedures" above the definition of the specific code at issue referring to "peripherals" surrounding contrast injection procedures (such as supplies "used for the injection of contrast materials, including local anesthetic, introduction of needles, and power injectors") as meaning that "CPT Code 36005 should be used to recover the costs associated with these supplies." P. Br. at 8. *citing* Hrg. Tr. at 122:18-123:21, and P. Ex. 19, at 3. For a provider to focus only on isolated language in an introductory description, while not reading or, if reading, not considering the content of the applicable CPT code definition, cannot constitute a reasonable inquiry. To rule otherwise would eviscerate the integrity of the CPT code system and the Medicare billing process.

The ALJ could also reasonably decline to credit Petitioner's contention that the record shows only "real world interactions and consensus decisions that occurred in good faith among several Drew employees, including the Petitioner" rather than a basis on which Petitioner should have known continued billing was improper. P. Br. at 9, citing P. Ex. 5 ¶ 11-12; P. Ex. 1 at 10; P. Ex. 10, at 62-63; Hrg. Tr. at 115-116, 127, 138. The record includes ample contrary evidence including: Ms. Terry's deposition testimony that Ms. Shelton told her after the 2004 meeting that she disagreed with Petitioner continuing to

use the code (I.G. Ex. 62, at 133) and feared she would be criminally liable for its use (*id.* at 182); billing collection supervisor Russell Jones's statement to an I.G. investigator that "the controversy surrounding procedure code 36005 already existed when he began his employment with Drew in 2001" (I.G. Ex. 56, at 1); and the statements of Luis Velasquez to the I.G. investigator that "the issue regarding 36005 was already a hot issue when he began . . . in 2002," that he told Ms. Shelton he "wasn't going to jail for Drew" over the use of the code, that he spoke with and emailed Ms. Shelton many times about the code, and that many other employees questioned the code but Drew continued to use it (I.G. Ex. 47).

We recognize that Petitioner relies on the fact that Ms. Terry also stated that she believed that CPT code 36005 was "legal to use until 2006" in support of his position that staff failed to alert him sufficiently to "the full nature of the coding issue." P. Br. at 11, *citing* P. Ex. 15 at 142. The surrounding context of the statement in her deposition to which Petitioner cites, however, is that she "felt it was wrong and at least immoral" and "[e]verything we looked at said it shouldn't be used," but that she was not certain it was illegal prior to 2006 largely because she did not know why the claims were being paid. I.G. Ex. 62, at 140-41. She reported that, from August 2004 on, "we all knew it was at least wrong." *Id.* at 163. She also testified that she talked directly to Petitioner about the "36005 issue" at least 3-10 times. *Id.* at 186. Moreover, in an interview with the I.G. inspector, Ms. Terry reported a conversation with Drew's defense attorneys in which they suggested that she was confusing events from 2006 when she asserted that Petitioner knew in 2004 the use of CPT code 36005 was improper. I.G. Ex. 60, at 1. She asserted that, on the contrary, reviewing all of the emails and memoranda shown to her by the Drew attorneys made her "even more positive" as to the timing and that she would "stake her life on the fact that [Petitioner] knew in 2004 that it was not proper to bill for" CPT code 36005. *Id.* at 1-2.

ii. Whether Petitioner's actions in 2006 demonstrate he was not aware of the misuse of CPT code 36005 before that period.

Petitioner relies heavily on his claims that in 2006 he "took prompt action to discontinue" the code's use and other corrective steps such as engaging outside counsel and an independent auditor and beginning a repayment process pursuant to their findings. P. Br. at 8. Based on his 2006 actions, he argues that --

> [t]here is no reasonable basis to infer that had [the 2006] additional clarifying information been available in 2004 Petitioner would have undertaken any different remedial action. The objective evidence and all reasonable inferences show that Petitioner would have acted in 2004 as he did in 2006 to correct a known coding error if complete information had been presented and understood.

Id. This argument does not provide a basis for overturning the ALJ Decision.

First, we note that Petitioner's framing of this argument distorts the situation in 2004. In 2004 as much as in 2006, Petitioner had an obligation as a provider to seek out "complete information" especially when confronted by questions about the use of a code. Yet, as discussed above, he did not take the steps that would be expected of a provider seeking to carry out that obligation. It is not reasonable to rely on an inference backward from what he did in 2006 to speculate that Petitioner's inaction in 2004 must mean he lacked adequate information to trigger action when the ALJ made direct findings that adequate information was available to Petitioner in 2004 to trigger further inquiry by any provider.

Second, the record reflects reasons that Petitioner may have felt pressure to act by January 2006 to which he was not subject in 2004. Radiologists, who did know the meaning of "extremity venography," had learned that Drew was billing under CPT code 36005. The record shows that these radiologists were alarmed because they understood the billing was improper and were concerned about "liability issues" because they had been appointed as Medical Directors at the affiliated Central Florida Radiology.[13] I.G. Ex. 49 (Dr. Reddy email); I.G. Ex. 64, at 132-133 (Dr. Locey's deposition). As of January 2006, Dr. Reddy was demanding the use of this "false" code be stopped. I.G. Ex. 49 (email to Petitioner). As of January or early February, Dr. Locey was not only demanding that the code be removed from the billing system but that Petitioner investigate the code's use and make restitution based on the investigation. I.G. Ex. 64, at 140, 193; *see also,* I.G. Ex. 62, at 216 (Randi Terry deposition stating that in early 2006 Dr. Locey was "clearly not going to let up about stopping use of the code" and was "just pounding to get [the billing codes] out"). Given the doctors' pressure on Petitioner in 2006, the ALJ could reasonably decline to infer that Petitioner's 2006 actions show that he was acting reasonably and in good faith in 2004 when he decided to continue to use of CPT code 36005.

iii. Whether the CPT Manual provisions were ambiguous and misled Petitioner into believing CPT code 36005 could be billed with MRIs and CT scans.

Petitioner argues that the ALJ erred in not considering evidence supporting his argument that ambiguity in CPT code 36005 justified his belief in 2004 that continued use of that code was proper. P. Br. at 7-8, 9, P. Reply Br. at 12-13. Petitioner asserts that the I.G. expert "confirmed that the ambiguity over the use of the code would not be easily known to anyone who is not a certified coder or radiologist." P. Br. at 8-10, citing Hrg. Tr. at 37. Petitioner mischaracterizes the cited testimony, which was as follows:

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[13] Central Florida Radiology was owned by Petitioner and "employed all the radiologists who provided the professional component of most of the MRI and CT Scans" performed by Drew. I.G. Ex. 5, at 1; I.G. Ex. 4, at ¶ 10; I.G. Ex. 6, at 2.

> Q. In connection with the documentation issues noted in your report you reviewed medical records and the billing records and in your assessment any certified coder or radiologist would have recognized that Code 36005 was not appropriate, correct?
>
> A. Correct.
>
> Q. But if someone was not a certified coder and was not a radiologist your opinion **may** be different, true?
>
> A. Correct.

(Emphasis added.) This testimony confirms that any "certified coder or radiologist" would be certain that the use of the code was inappropriate and that the result might be different for a non-expert. It nowhere suggests that there was an "ambiguity" in the code or that its terms would not be clear enough to alert a non-expert to the need to at least consult a certified coder, a radiologist or other expert before using the code as Petitioner did. Moreover, as discussed above, the I.G. expert stated in his direct testimony that the CPT radiology guidelines "explicitly codified" the "concept" that contrast administration services are part of the MRI or CT scan procedure and contrast injections should not be billed over and above the applicable MRI or CT scan code. I.G. Ex. 17, at 5.

Petitioner also points to an exchange between a Medicare carrier representative and Drew's compliance counsel in 2006. P. Br. at 9, *citing* P. Ex. 3. The counsel wrote the carrier for "clarification" on CPT code 36005. A carrier representative responded that his request had been assigned to her and that "[a]s you stated these guidelines can be a little confusing . . . ." P. Ex. 3. The ALJ reasonably construed the representative's reply as merely "a mild expression of agreement by the carrier's representative with Drew's agent's contention that the CPT codes in general 'can be a little confusing.'" ALJ Decision at 8. Such a mild expression cannot reasonably be viewed as a concession of ambiguity or confusion that a provider charged with the duty to understand Medicare and Medicaid billing requirements would not be expected to understand or be capable of clarifying. Petitioner also relies on the fact that it took "nearly three months" for the contractor to respond (and say the code could not be billed with MRIs and CT scans). P. Reply Br. at 13, *citing* I.G. Ex. 65. We decline to infer that a code was confusing simply because it took a contractor some amount of time to respond.

Petitioner asserts that Dr. Locey "had to consult numerous reference sources to understand the coding issues before concluding the code was in error." P. Reply Br. at 13, *citing* I.G. Ex. 64, at 142-148. This misrepresents the record. Dr. Locey testified that, upon being told by Ms. Shelton and Ms. Terry on January 16, 2006 that Drew was billing an injection code for venography with contrast-enhanced MRIs and CT scans, he told them at once that "it was an improper code, and Drew should immediately stop using

it. . . . It was very clear that that was an improper code." I.G. Ex. 64, at 140. He went on to say that his "remaining question" was whether any alternative code could be used and that he did make inquires about that question before concluding that no injection code should be billed. *Id.* at 140 and 142.

Finally, Petitioner cites the testimony of the auditor Drew hired in 2006, Raymond Howard. Mr. Howard stated:

> During the time period 2002 to 2006, I was aware that there was confusion in the health care community on whether CPT code 36005 could be used as a code for contrast services. I had received phone calls from providers other than Drew with questions about billing 36005 as a code to capture contrast services.

P. Br. at 9, citing P. Ex. 7 at ¶ 9. The ALJ stated that Mr. Howard's assertion was "without foundation" because Mr. Howard did not provide "any evidence to support his claims that the there was 'confusion' in the provider community over the use of this code provision." ALJ Ruling on Inspector General's Motion to Exclude Petitioner Ex. 7, at 2 (Feb. 8, 2011). A failure to support a factual assertion, particularly one central to the issue at hand, with evidence or pertinent detail is reasonable grounds to accord less or no weight to the assertion. Additionally, we note that, while Mr. Howard says he received "calls" from providers "about billing 36005 as a code to capture contrast services," he does not say, as Petitioner would have us infer, that those providers asked whether CPT code 36005 could be used to capture contrast services provided with MRIs or CT scans.

iv. The ALJ did not err in finding that Petitioner had a personal financial incentive to file claims under CPT code 36005.

Petitioner argues that the ALJ erred in finding that "Petitioner had an obvious personal financial motive to file false claims." *See, e.g.,* P. Br. at 5, citing ALJ Decision at 5 (which actually says "There is no question that Petitioner had a financial incentive to file false claims."). Petitioner objects to this finding on the grounds that the "I.G. did not present evidence of personal financial motive or benefit. More significantly, in assessing recklessness, the finding does not take into account factors recognized by the DAB as suggesting improper motive, i.e. discussion of reimbursement amount, revenue disparity and the like." P. Br. at 5. He concludes that the "absence of this evidence should favorably lead to a finding that Petitioner did not intend to submit false claims as it has in other DAB cases." *Id.*

This argument is without merit. Petitioner admitted to understanding in 2004 that Drew was "getting" 70 or 90 dollars for each claim under CPT code 36005.[14] P. Ex. 2, at 231, 22-25. Petitioner was the sole owner of Drew and responsible for the decision to keep billing under the code. Absent evidence to the contrary, the ALJ reasonably inferred that Petitioner had an incentive to continue the code because he understood that the revenue generated by thousands of claims under the code (over a million and a half dollars in federal reimbursement and uncalculated amounts from private insurers and individuals) would inure ultimately to his benefit as the owner of the business. Petitioner's situation is thus entirely unlike that of the employee who prepared the company's cost reports containing false claims but did not personally benefit from the resulting reimbursement. In that situation, the Board upheld an ALJ's reduction of penalties to reflect, among other factors, the absence of an apparent financial motive. *Thomas M. Horras,* DAB No. 2015 (2006). Indeed, Petitioner's position is more like that of Mr. Horras, who was the sole owner of the home health agency and was ultimately responsible for the submission of false claims.

4. The ALJ did not err in upholding eight-year duration of the exclusion.

The Board has previously recognized that "[i]t is well-established that section 1128 exclusions are remedial in nature, rather than punitive, and are intended to protect federally-funded health care programs from untrustworthy individuals." *Donald A. Burstein, Ph.D.*, DAB No. 1865, at 12 (2003), *citing Patel v. Thompson*, 319 F.3d 1317 (11th Cir. 2003), *cert. denied*, 123 S.Ct. 2652 (2005); *Mannocchio v. Kusserow*, 961 F.2d 1539, 1543 (11th Cir. 1992). In reviewing whether "[t]he length of exclusion is unreasonable" under 42 C.F.R. § 1001.2007(a)(1)(ii), the ALJ may not substitute his judgment for that of the I.G. *See, e.g., Barry D Garfinkel, M.D.* DAB No. 1572, at 6-7, 10-11 (1996) (ALJ's role "was not to determine what period of exclusion would be 'better'"). Instead, the ALJ is to determine whether the period of exclusion imposed by the I.G. was within a reasonable range, based on demonstrated criteria. *Id.*; 57 Fed. Reg. 3298, 3321 (Jan. 29, 1992). The preamble to Part 1001 indicates that the I.G. has "broad discretion" in setting the length of an exclusion in a particular case, based on the I.G.'s "vast experience" in implementing exclusions. 57 Fed. Reg. at 3321.

In setting the duration of a section 1126(b)(7) exclusion, the I.G. considers the factors set forth at 42 C.F.R. § 1001.109(b):

> (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;

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[14] In fact, as of 2004, Drew was receiving for each paid claim more than three times the amount Petitioner acknowledged. *See,* I.G. Ex. 1, at 103.

(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.

Relying on these factors, the ALJ found the I.G.'s decision here was reasonable. ALJ Decision at 12-15. The ALJ reasoned as follows:

- The "nature and circumstances" of Petitioner's false claims were "extremely serious," involving over 9,500 false claims over a period of nearly six years and unjustified reimbursement of more than $1.6 million. The ALJ found that "[t]hat pattern of false claims, extending over a period of six years, is evidence of a very high degree of untrustworthiness."[15] *Id.* at 13.

- Petitioner's culpability for these false claims was "very high." *Id.* at 13. While the ALJ did not find that "Petitioner deliberately set about to defraud Medicare and the Florida Medicaid program," he did find 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." *Id.* at 13-14.

- The ALJ took into consideration the fact that "Petitioner ordered Drew Medical to return about $700,000 of its ill-gotten reimbursement to Medicare." *Id.* at 14. The ALJ treated this as a "mitigating factor," stating that he "might have sustained an exclusion of more than eight years had Petitioner had not made partial voluntary restitution." *Id.*

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[15] As discussed previously, the ALJ misstated the time period over which the more than 9,500 claims were made. The claims filed within the three-year statute of limitations numbered 4,492 claims for Medicare and 298 claims for Medicaid. However, in weighing the reasonableness of the length of an exclusion, the ALJ may, as he did here, consider all relevant information about the nature and circumstances surrounding the acts at issue, which includes Drew Medical's false billing from January 1, 2000 to May 1, 2006 of over 9,500 claims. 42 C.F.R. § 1001.901(b)(1).

- The ALJ found unpersuasive Petitioner's assertion that "an exclusion will effectively put him out of business and force the shutdown of Drew Medical [and,] according to Petitioner, put many individuals out of work." *Id.* at 14. The ALJ noted that exclusion applies to "Petitioner and not to the company he owns and operates" so that "[n]othing prohibits Petitioner from severing his interest from Drew Medical" and "[p]resumably, the entity may continue under different ownership so long as Petitioner has nothing to do with it." *Id.* at 15.

Based on these findings the ALJ concluded that the I.G.'s decision to exclude Petitioner for eight years was reasonable.

On appeal, Petitioner argues that there was "no evidence of a pattern of poor decisions or systemic billing issues attributable to Petitioner," of "improper motive or avarice," or of "other conduct in addition to billing errors" that would support a finding of a "pattern of untrustworthy conduct." P. Br. at 23. These assertions do not provide a basis for disturbing the ALJ's determination.

- Petitioner is incorrect in asserting that there was no evidence of "systemic billing issues attributable to Petitioner." Based on the evidence, the ALJ found that Petitioner –

  > failed to institute [billing] reviews at any time prior to 2006 that should have revealed Drew Medical's impermissible 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.

  ALJ Decision at 8. Moreover, Dr. Locey testified that when he, as part of the 2006 Code Review Committee, reviewed Drew Medical's billing practices, he found the billing system was "extremely flawed." Hrg. Tr. 78; *see also id.* at 113 (billers billing for what was ordered rather than what was actually done); *id.* at 132 (lumbar x-ray billed a higher rate than proper); *id.* at 133 (people being billed "for things they did not get done"); *id.* at 136 ("double billing"). Finally, we note that the I.G. expert, in reviewing a sample of Drew's false claims, found those records suggested that Drew "at least occasionally and likely frequently engaged in the practice of upcoding" certain types of pelvic scans, and recommended "further analysis to determine whether this practice is as widespread" as Drew's misuse of CPT code 36005. I.G. Ex. 17, at 15.

- As to the alleged lack of "evidence of improper motive or avarice," we reject Petitioner's argument that the I.G. was required to present such evidence. Moreover, ALJ could reasonably infer that Petitioner knew the fraudulent gains realized by Drew Medical under CPT code 36005 inured ultimately to his benefit and failed to stop those gains when first alerted to their impropriety.

Petitioner argues that the ALJ erred in discerning "little difference between the level of culpability manifested by a person who deliberately defrauds and one who files claims indifferent to their truth." P. Reply at 19, citing ALJ Decision at 15. Petitioner cites the case of *Rudra Sabaratnam, M.D. and Robert I. Bourseau*, DAB CR1660 (2007) in which an ALJ reduced the length of an exclusion from 15 to 10 years on the ground that the individual had not acted deliberately to defraud government health care programs. P. Reply at 20.

We reject this argument. The ALJ found that Petitioner had recklessly approved the continued use of an automated code that would falsely, repeatedly, and indefinitely bill a particular CPT code. In discussing the distinction between recklessness and intentional behavior, the ALJ focused on the impact of Petitioner's conduct on federal health care programs. The ALJ reasonably found that Petitioner's reckless disregard for the foreseeable and significant consequences of his decision indicated high culpability and untrustworthiness. Moreover, Petitioner's failure to correct, until 2006, the false claims Drew filed shows that he was more interested in protecting Drew's financial well-being to the detriment of the federal health care programs that he had falsely billed.

Petitioner points to other section 1128(b)(7) exclusions in which ALJs reduced exclusions to five or fewer years. P. Br. at 23-24; P. Reply at 19, citing *Stephen Winters*, DAB CR1246 (2004); *Robert Spencer, D.P.M.*, DAB CR721 (2000). He points out that the individuals in these cases did not "self identify their billing issues, bring in an outside auditor, or voluntarily pay back the wrongfully received funds before the government even commenced an investigation." P. Reply at 19. Petitioner argues that the ALJ did not consider his corrective actions as a mitigating factor. P. Br. at 23. Petitioner further argues that "[i]t is not in accord with precedent to exclude an individual for eight years that took greater strides to comply than persons excluded for five or fewer years." *Id.* We reject these arguments. First, comparisons with other cases are not controlling and of limited utility given that exclusion factors "must be evaluated based on the circumstances of a particular case" (57 Fed. Reg. at 3314), which can vary widely. *See Paul D. Goldenheim, M.D.*, DAB No. 2268, at 29 (2009), *aff'd Friedman v. Sebelius,* 755 F.Supp.2d 98 (D.D.C. 2010). Indeed, the cited cases involve vastly different facts from one another and from this case. (*Spencer* involved claims for 28 Medicare recipients, not the thousands at issue here. *Winters* involved contributions to a pension plan.) Second, as we have repeatedly held, ALJ decisions are not binding precedent on the Board or

even on other ALJs. *See, e.g. Mark B. Kabins*, DAB No. 2410 (2011); *Maysville Nursing and Rehabilitation Facility,* DAB No. 2317 (2010). Third, while Petitioner relies heavily on his corrective actions in 2006, the ALJ did not expressly find (and it is not necessary to infer) that he would have actually taken all of these actions absent Dr. Locey's pressure on him (ultimately including the filing of a FCA Act suit against Petitioner and Drew) to identify the false claims and make restitution. Fourth, the ALJ specifically stated that he was treating Petitioner's corrective actions as a mitigating factor and otherwise would have considered imposing a longer exclusion.

Petitioner points out that two of the factors did not apply to him ("a documented history of criminal, civil or administrative wrongdoing" and "has not been subject to any adverse action in which he has been held liable and subject to actual sanctions" - sections 1001.901(b)(3) and (4)). P. Br. at 24-25. This fact is irrelevant as long as the factors that do apply are adequate to support the I.G. duration determination, as we conclude they are.

Therefore, we conclude that the ALJ did not err is upholding the I.G.'s decision to exclude Petitioner for eight years.

Conclusion

For the preceding reasons, we uphold the ALJ's decision.

/s/
Stephen M. Godek

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan
Presiding Board Member