Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Janet Elizabeth Despot, M.D.,	)	
(OI File No. 7-05-40142-9).	)	Date: October 26, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-09-426
	)	Decision No. CR2023
The Inspector General.	)	
	)	

DECISION

I sustain the determination of the Inspector General (I.G.) to exclude Petitioner, Janet Elizabeth Despot, M.D., from participating in Medicare, Medicaid, and all federal health care programs for a period of five years. I find that the I.G. is authorized to exclude Petitioner pursuant to section 1128(a)(1) of the Social Security Act (Act), and that the five-year exclusion imposed by the I.G. is the minimum period of exclusion mandated by the Act. Act, section 1128(a)(1).

I. BACKGROUND

Petitioner is a medical doctor specializing in allergies and immunology. Since 1997, she has operated a practice titled "Cardinal Respiratory, P.C." located in Springfield, Illinois. Petitioner Exhibit (P. Ex.) 2, at 1-2. On February 4, 2008, Petitioner entered a plea of guilty to one misdemeanor count of "Illegal Medicare Balance Billing" in violation of 42 U.S.C. § 1320a-7b(e) in the United States District Court for the Central District of Illinois. I.G. Exhibit (I.G. Ex.) 2, at 1. In her plea agreement, Petitioner stipulated to the factual basis for her plea, admitting,

> On or about October 6, 1997, Janet Despot signed a "Medicare Participating Physician or Supplier Agreement" under Title 42, United States Code, Section 1395u(h)(1). This agreement provided, among other things, that "the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered . . . ." In essence, to get the benefits of being a participating provider under the Medicare program, Janet Despot agreed to accept the Medicare-approved amount determined by the carrier as payable for the service as full payment for the service. Medicare would typically pay 80% percentage of this amount, and, presuming any deductible had been met, the provider would be able to collect only the "co-payment" from the patient. The co-payment is the amount between the "allowed" amount determined by Medicare, and the amount actually paid by Medicare (typically 20% of the allowed amount). Any additional amount charged for the service, or "balance," was required to be "written off" by the provider and not billed to the patient.
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> During this same period of time, Janet Despot employed her husband, Rickey E. Weir, as the "business manager" for Cardinal Respiratory. Weir was allowed to have the primary responsibility for submitting claims for Despot's medical practice to insurance companies and individuals for payment. Between December, 1997 and October, 2006, Janet Despot was personally notified on several occasions by patients and representatives of the Illinois Department of Professional Regulation that insurance companies and her patients were being improperly billed, and, when the insurance companies did not pay, or did not pay enough, the patients were "balance billed" for her services, and charged interest and finance charges beyond the allowed amount.
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> The abusive billing practices continued from in or about December, 1997 through October, 2006. During this time, Janet Despot was told that Cardinal Respiratory repeatedly charged patients for amounts in excess of the amount deemed by the Medicare carrier to be payable, and knowingly and willfully allowed such to continue in violation of the Participating Provider agreement. Any inquiries regarding the billing practices of Cardinal Respiratory were referred to Rickey Weir.

I.G. Ex. 3, at 9-10; P. Ex. 1, at 9-10.

The I.G. notified Petitioner by letter dated February 27, 2009, that as a result of her guilty plea, she was being excluded from Medicare, Medicaid, and all other federal health care programs for a period of five years. I.G. Ex. 1. The I.G. cited section 1128(a)(1) of the

Act as the basis for her exclusion. By letter dated April 30, 2009, Petitioner requested a hearing.[1]

I held a prehearing conference, by telephone, on May 20, 2009. During that conference, I noted that there did not appear to be material facts in dispute which might necessitate a hearing at which I would hear witness testimony, but that the dispute instead appeared to concern legal issues only. The I.G. agreed. Petitioner agreed that there did not appear to be material facts in dispute, but asserted she wanted an in-person hearing. As neither party could assert material facts in dispute, and only legal issues appeared to be in dispute, I set a briefing schedule. I noted that either party was free to request an in-person hearing in their briefing. I informed the parties that if I found material facts in dispute I would schedule another prehearing conference to discuss scheduling an in-person hearing.

The I.G. submitted a brief (I.G. Br.) accompanied by I.G. Exs. 1-4. Petitioner submitted a response (P. Br.) accompanied by P. Exs. 1 and 2. The I.G. submitted a reply, accompanied by I.G. Ex. 5. In the absence of objection, I admit I.G. Exs. 1-5 and P. Exs. 1 and 2.

II. CONTROLLING STATUTES AND REGULATIONS

Section 1128(a)(1) of the Act requires the Secretary of Health and Human Services (Secretary) to exclude from participation in Medicare, Medicaid, and all other federal health care programs, any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under the Medicare or Medicaid programs. 42 U.S.C. § 1320a-7(a)(1).

An exclusion imposed under section 1128(a)(1) must be for a period of at least five years. Act, section 1128(c)(3)(B); 42 U.S.C. § 1320a-7(c)(3)(B). Pursuant to 42 C.F.R. § 1001.102(b), no exclusion pursuant to section 1128(a)(1) may be for less than five years.

[1] On May 15, 2009, Petitioner moved to stay proceedings in this case for six months while she pursued a waiver of her exclusion with the I.G. During the May 20, 2009 prehearing conference, I denied Petitioners request, noting that whether or not the I.G. grants a waiver of the exclusion, the I.G.'s decision-making process has no impact on my decision as to whether the I.G. had a basis upon which to exclude Petitioner and whether the length of the exclusion imposed is unreasonable. 42 C.F.R. § 1001.2007(a)(1).

An individual is "convicted" of a criminal offense within the meaning of section 1128(i) of the Act –

(1) when a judgment of conviction has been entered against the individual or entity by a Federal, State, or local court;

(2) when there has been a finding of guilt against the individual or entity by a Federal, State, or local court;

(3) when a plea of guilty or *nolo contendere* by the individual or entity has been accepted by a Federal, State, or local court; or

(4) when the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

Act, section 1128(i); 42 U.S.C. § 1320a-7(i).

42 C.F.R. § 1001.2007(a)(1)(i) grants an administrative law judge (ALJ) the authority to address whether a legal basis for the imposition of an I.G. sanction exists, and 42 C.F.R. § 1001.2007(a)(1)(ii) grants an ALJ the authority to address whether the length of the exclusion imposed is reasonable. However, where the exclusion imposed under section 1128(a)(1) of the Act is for five years, that is the minimum, mandatory period of exclusion contemplated by the Act, and the ALJ does not have the authority to consider whether the length of the exclusion is unreasonable. 42 C.F.R. § 1128(c)(3)(B).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Issue

The legal issues before me in this case are:

- Whether there is a legal basis for the imposition of the exclusion under section 1128(a)(1) of the Act.

- Whether summary judgement is appropriate.

B. Findings and Discussion

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding in italics and bold below as a separate heading. I discuss each Finding in detail.

1. Summary disposition is appropriate in this case.

Summary disposition is appropriate where there are either no disputed issues of material fact and the only questions that must be decided involve application of law to the undisputed facts, or the moving party must prevail as a matter of law even if all disputed facts are resolved in favor of the party against whom the motion is made. A party opposing summary disposition must allege facts which, if true, would refute the facts relied upon by the moving party. *See* Fed. R. Civ. P. 56(c); *Thomas E. Strebel,* DAB CR1771 (2008); *Michael J. Rosen, M.D.,* DAB No. 2096 (2007).

In her brief, Petitioner requests an in-person hearing. P. Br. at 9-10. Petitioner asserts that at the time she submitted her brief she did not know whether the I.G. would dispute material facts raised in Petitioner's brief and that she was making the request "to preserve Petitioner's rights to an in-person hearing should the Inspector General's reply raise material facts in dispute."

Summary disposition is appropriate. Petitioner has not disputed an issue of material fact. As there are no material facts in dispute, I decide this case based solely on the factual basis as stated in Petitioner's Plea Agreement and Stipulation of Facts. P. Ex. 1; I.G. Ex. 3.

2. Petitioner was convicted within the meaning of section 1128(i) of the Act.

An exclusion under section 1128(a)(1) of the Act requires that two elements be shown: (1) that the individual or entity has been convicted of a criminal offense as defined at section 1128(i) of the Act; and (2) that the criminal offense be related to the delivery of an item or service under title XVIII (Medicare) or under any state health care program (Medicaid). The I.G. bears the burden of persuasion to prove, by a preponderance of the evidence, that both elements have been met. 42 C.F.R. §§ 1005.15(b)(1), (d).

There is no dispute that the first element has been met. Petitioner admits she pled guilty to misdemeanor balance billing under the Act. P. Br. at 2. The I.G. has established that Petitioner pled guilty to a one-count misdemeanor violation of 42 U.S.C. § 1320s-7b(e), Illegal Medicare Balance Billing, in the United States District Court for the Central District of Illinois. I.G. Ex. 2. Petitioner thus was "convicted" of a criminal offense within the meaning of section 1128(a)(1) of the Act.

Petitioner asserts, however, that the second element of section 1128(a)(1) has not been met. Specifically, she asserts that her misdemeanor plea is not related to the delivery of an item or service under the Medicare program. P. Br. at 1.

3. Petitioner's conviction is related to the delivery of an item or service under Medicare.

Under section 1128(a)(1) of the Act, the I.G. must exclude an individual if that individual's conviction relates to the delivery of an item or service under Medicare or Medicaid. 42 U.S.C. § 1320a-7(a)(1). ALJs and the Departmental Appeals Board (DAB) have defined "related to" to mean a "nexus or common sense connection" between the conviction and the stated basis for exclusion. *Scott D. Augustine*, DAB No. 2043 (2006); *Timothy Wayne Hensley*, DAB No. 2044 (2006). The DAB stated in *Augustine* that,

> Section 1128(a)(1) requires merely that an offense be "related to" the delivery of an item or service under a covered program. It does not require that the offense result in a delivery and therefore does not require an actual delivery of an item or service. Based on the plain meaning of the word "related," the Board has repeatedly held that an offense is "related to" the delivery of an item or service under a covered program if there is a common sense connection or nexus between the offense and the delivery of an item or service under the program. *See, e.g., Berton Siegel, D.O.*, DAB No. 1467 (1994); *Thelma Walley*, DAB No. 1367 (1992); *Niranjana B. Parikh, M.D.*, DAB No. 1334 (1992). Therefore, the Board has determined that an offense committed by someone providing billing or accounting services was related. *Jack W. Greene*, DAB No. 1078 (1989), *aff'd, Green v. Sullivan*, 731 F. Supp. 835 (E.D. Tenn. 1990); *Michael Travers, M.D.*, DAB No. 1237 (1991), *aff'd, Travers v. Sullivan*, 791 F. Supp. 1471, 1481 (E.D. Wash. 1992) and *Travers v. Shalala*, 20 F.3d 993 (9th Cir. 1994); that no showing of harm to a protected program was necessary in order for an offense to be related, *Neil R. Hirsch, M.D.*, DAB No. 1550 (1995), *aff'd, Hirsch v. Shalala*, No. 96-4008 (C.D. Ill. Nov. 4, 1996); *Paul R. Scollo, D.P.M.*, DAB No. 1498 (1994); that an offense could be related even if the services were actually provided by an entity different from the individual being excluded, *Napoleon S. Maminta, M.D.*, DAB No. 1135, at 7 (1990); that an offense could be related even if no service or item was actually delivered, *Francis Shaenboen, R.Ph.*, DAB No. 1249, at 4 (1991); that an offense could be related even if it did not directly involve the delivery of items or services, *Salvacion Lee, M.D.*, DAB No. 1850 (2002); and that an offense could be related even if the individual did not personally engage in the scheme or was not aware of the scheme that resulted in the delivery of the mislabeled pharmaceuticals under a covered program, *Lyle Kai, R.Ph.*, DAB No. 1979 (2005), *aff'd, Kai v. Leavitt*, Civ. No. 05-00514 BMK (D. Haw. 2006).

Scott D. Augustine, DAB No. 2043, at 5-6.

Petitioner asserts that there is no common sense connection or "nexus" between the criminal offense to which she pled guilty and an item or service under the Medicare program.[2] Petitioner asserts that finding an offense is program-related financial misconduct is insufficient without also finding a nexus to the delivery of items or services under one of the covered programs, citing *Berton Siegel, D.O.*, DAB No. 1467 (1994). Petitioner asserts that just because her offense is called "Medicare balance billing" in the plea documents does not necessarily mean the offense was "related to" the delivery of Medicare items or services because, citing *Paul R. Scollo, D.P.M.*, DAB No. 1498, Petitioner asserts that it is not the particular label assigned to the crime that determines whether an offense is related to the delivery of an item or service under Medicare, but the actions and circumstances surrounding the offense. *Id.* Petitioner asserts that a criminal offense must be related to an item that is actually payable by the Medicare program, and asserts here that her plea agreement states that her balance billing violation occurred when insurance companies and patients were billed for non-Medicare allowable items or services and that therefore the balance billing activities fall outside of the mandatory exclusion authority. Petitioner asserts that Medicare carrier involvement alone is insufficient to establish the requisite nexus, as the exclusion authority does not extend to all matters involving the Medicare program or Medicare patients. P. Br. at 5-7.

Petitioner's arguments misapprehend the nature of the necessary nexus. Petitioner's conviction of "Illegal Medicare Balance Billing" is on its face related to the delivery of an item or service under Medicare. Petitioner's criminal offense is a violation of 42 U.S.C. § 1320a-7b(e). I.G. Ex. 2. That section is entitled "[c]riminal penalties for acts involving federal health care programs." The subsection to which Petitioner pled guilty provides,

[2] Because of that, Petitioner suggests that the case be returned to the I.G. for proceedings under the permissive exclusion authorities, where the I.G. could forego exclusion or take into account as a mitigating factor Petitioner's lack of participation in the billing activities of her office. As I find Petitioner's exclusion to be program related, Petitioner's exclusion is mandatory. I note that section 1128(b) of the Act is indeed permissive, and it does apply to certain misdemeanor offenses. However, numerous ALJ and appellate decisions determined that, in matters where a conviction triggers both the mandatory (section 1128(a)) and permissive (section 1128(b)) exclusion provisions, the Secretary does not have discretion as to which provision to impose. The Secretary is required to implement the mandatory exclusion. *See, e.g., Touradj Farhadi, M.D.*, DAB CR1072 (2003); *Boris Lipovsky, M.D.*, DAB No. 1363 (1992); *Kenneth M. Behr*, DAB No. 1997 (2005); *Lorna Fay Gardner*, DAB No. 1733 (2000). Moreover, Petitioner's lack of participation in the billing activities of her office would not be a mitigating factor under any of the permissive exclusion authorities. 42 C.F.R. § 1001 Subpart C – Permissive Exclusions.

> Whoever accepts assignments described in section 1842(b)(3)(B)(ii) [42 U.S.C. § 1395a(h)(1)] and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor . . . .

42 U.S.C. § 1320a-7b(e). The subsection makes it a criminal offense to violate the terms of a Medicare participating physician or supplier agreement. Under such an agreement, a physician agrees to accept assignment of the Medicare Part B payment for all services for which a physician is eligible to accept assignment under Medicare law and regulations and to refrain from collecting from any Medicare beneficiary reimbursement for covered services that is greater than the applicable deductible and coinusurance. I.G. Ex. 3, at 9-10; I.G. Ex. 4, at 1. Because the basis for this offense is a violation of the Medicare participation agreement, which governs how a physician is to be paid for Medicare services provided by the physician, the criminal offense has an, as noted above, on its face nexus or common sense connection to the delivery of an item or service (here payment for physician services) under the Medicare program. Petitioner's arguments above are thus irrelevant. But, moreover, Petitioner's plea agreement also establishes a nexus between the criminal offense to which she pled and the delivery of an item or service under Medicare, because Petitioner's practice charged Medicare patients for items or services she provided in amounts that exceeded the amount deemed by the Medicare carrier to be payable.[3] I.G. Ex. 3, at 10; P. Ex. 1, at 10.

While Petitioner has argued that her excess charges were for non-covered supplies, her contention that the charges were for non-covered supplies is not supported by the record. Since the Medicare provider or supplier agreement only applies to services for which a physician is eligible to accept assignment, it is necessarily a charge for Medicare services. Otherwise there would not have been a violation of 42 U.S.C. § 1320a-7b(e). Petitioner has also offered no factual support for her contention. The plea agreement is silent regarding the nature of these supplies. However, her plea agreement does set forth the precise nature of the excess charges and contradicts her. The plea agreement explains that the balance billing charges were based on excess, fraudulent charges for Medicare covered items or services (fraudulently unbundled supplies). I.G. Ex. 5, at 17-27.

Petitioner also asserts that mandatory exclusion in her case is inconsistent with the legislative intent of the Act because it would not further the legislative goal of protecting the programs from fraud or abuse or protecting Medicare beneficiaries from incompetent practitioners or inappropriate or inadequate care since her balance billing did not involve the Medicare program. Moreover, Petitioner asserts that it was her husband who was

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3 Medicare pays a participating physician 80% of the approved amount for a service, assuming the patient's deductible has been met, and the physician can collect the remaining 20% from the patient, whether directly or through a secondary insurance policy. *See* I.B. Ex. 3, at 9.

directly and primarily responsible for the wrongdoing. She asserts that the prosecution in her criminal case acknowledged that Petitioner is unlikely to pose further harm to the programs and there "was never even a hint of any allegation regarding [her] quality of care." P. Br. at 7-8.

I agree with the I.G. that Petitioner's argument is essentially irrelevant, because the I.G has no discretion and must exclude Petitioner for five years. However, Petitioner is mistaken in her belief that exclusion in her case is inconsistent with the legislative intent. As noted above, Petitioner's conviction on its face involved the Medicare program. Petitioner's argument that her balance billing did not involve Medicare is incorrect – she was convicted of billing for items or services her provider agreement with Medicare explicitly forbid her from billing. Petitioner's inaction, in the face of her husband's wrongdoing, and her failure to correct her billing in the face of repeated notification of improper balance billing by responsible authorities, shows that for a lengthy period she was not capable of protecting Medicare beneficiaries from inappropriate billing (and appropriate billing for goods and services is a necessary part of the care that her office provided her patients). One purpose of exclusion is to protect the Medicare and Medicaid programs from untrustworthy providers by providing a period of time for that provider to demonstrate that he or she can be trusted. In the case of mandatory exclusion, Congress has determined by statute that the period of time necessary is five years.

4. Petitioner's exclusion for a period of five years is the mandatory minimum period as a matter of law.

An exclusion under section 1128(a)(1) of the Act must be for a minimum mandatory period of five years, as set forth in section 1128(c)(3)(B) of the Act:

> Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years. . . .

When the I.G. imposes an exclusion for the mandatory five-year period, whether or not the length of the exclusion is unreasonable is not an issue. 42 C.F.R. § 1001.2007(a)(2). Aggravating factors that justify lengthening the exclusion period may be taken into consideration, but the five-year period of exclusion cannot be shortened. Petitioner was convicted of a criminal offense related to the delivery of an item or service under Medicare. As a result of Petitioner's program-related conviction, the I.G. was required to exclude her for at least five years.

IV. CONCLUSION

Sections 1128(a)(1) and 1128(c)(3)(B) of the Act mandate that Petitioner be excluded from Medicare, Medicaid, and all federal health care programs, for a minimum, mandatory period of five years because of her conviction of a criminal offense related to the delivery of an item or service under Medicare. I therefore conclude that the I.G. properly excluded Petitioner from program participation, and I uphold the five-year exclusion.

/s/
Alfonso J. Montano
Administrative Law Judge