DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Appeals Board

Civil Remedies Division

In the Case of:	)	
	)	
The Inspector General,	)	DATE: December 5, 1989
	)	
- v. -	)	
	)	Docket No. C-55
Corazon C. Hobbs, M.D.,	)	DECISION CR 57
	)	
Respondent.	)	
	)	

DECISION AND ORDER

In this case, the Inspector General (I.G.) of the United States Department of Health and Human Services (DHHS) issued a Notice of Determination (Notice) on July 29, 1988, informing Corazon C. Hobbs, M.D. (Respondent) that the I.G. was seeking civil monetary penalties of $55,500.00, assessments totalling $3,005.77, and a five year exclusion of Respondent from participation as a medical provider in the Medicare, Medicaid, and other federal and state health care programs. The I.G. alleged that Respondent had violated the Civil Monetary Penalties Law (CMPL) and its implementing federal regulations (Regulations) by presenting false or improper claims for Medicaid payment. The I.G. alleged that Respondent had claimed to have provided 111 medical services ("office visits"), during the period from August 1982 to October 1984, and that Respondent knew, had reason to know, or should have known that the services were not provided as claimed.

Respondent filed a timely answer (Request) denying the I.G.'s allegations, challenging the proposed sanctions, and requesting a hearing before an Administrative Law Judge (ALJ).

APPLICABLE FEDERAL STATUTES AND REGULATIONS

I. Statutes.

This case is governed by the Civil Monetary Penalties Law (CMPL), Section 1128A of the Social Security Act (Act), 42 U.S.C. 1320a-7a (42 U.S.C.A. 1320a-7a, West Supp. 1989).

II. Regulations.

The governing federal regulations (Regulations) are codified in 42 C.F.R. sections 1003.100 through 1003.133 (1988).

BACKGROUND [1]

I. The State Charges And The Stipulation of No Conviction.

Respondent was indicted by the State of Hawaii on June 26, 1985 on 119 counts of Medicaid fraud and one count of theft. J. Ex. 1. Respondent pleaded nolo contendere to the one count of theft and the 119 fraud counts were nolle prosequied "with prejudice" on February 21, 1986. J. Ex. 1. On May 13, 1986, the State of Hawaii released Respondent from any claims or causes of action arising

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[1] The citations to the record in this Decision and Order are as follows:

May 1989 Stipulation of Facts	J. Ex. 1/(no.)
Supplemental Stipulations	J. Ex. 2/(no.)
Second Supplemental Stipulations	J. Ex. 3/(no.)
Hearing Transcript	Tr. (p.)
Respondent's Exhibits	R. Ex. (no./p.)
Respondent's Brief	R. Br. (p.)
Respondent's Reply Brief	R. Rep. Br. (p.)
I.G.'s Exhibits	I.G. Ex. (no./p.)
I.G.'s Brief	I.G. Br. (p.)
I.G.'s Reply Brief	I.G. Rep. Br. (p.)
ALJ Findings of Fact and Conclusions of Law	FFCL (no.)
April 18, 1989 ALJ Ruling	ALJ Ruling (p.)

out of the 119 false claims submitted by Respondent. On August 15, 1988, an order was entered granting the motion to terminate supervision and dismissal of the first-degree theft charge. R. Ex. 6. Of the 119 counts of Medicaid fraud nolle prosequied by the State of Hawaii, 111 are the subject of this CMPL action.

As a result of the plea, Dr. Hobbs was obligated by the court to serve 500 hours of community service. In addition, pursuant to the "Release Agreement" with the State of Hawaii, Respondent paid $1,123.61 in restitution and $1,122.00 in costs. J. Ex. 1/12. On July 29, 1988, the court dismissed the aforementioned charge of Theft in the First Degree. J. Ex. 1/13. Under the facts of the case, Respondent has not been convicted of a crime in connection with the claims in this case. J. Ex. 1/14.

II. The I.G.'s Notice And Statement Of The Case.

The I.G.'s Notice contained a schedule of false claims identifying 111 claims which the I.G. alleged were not provided as claimed. In addition, the Notice specified the factors used by the I.G. in determining the amount of penalties and assessments, and period of exclusion. Penalties of $55,500.00 (or $500 per claim) were proposed, along with assessments of $4,129.38 and an exclusion of five years. A credit of $1,123.61 was allowed as an offset against the assessments, leaving assessments of $3,005.77. This credit reflects restitution paid by Respondent to the State of Hawaii.

In his Post-Hearing Brief, the I.G. proposed penalties of $111,000, an increase based on additional aggravating circumstances. I.G. Br. 62, 63. The I.G. also stated that the appropriate assessment figure should be revised to $2,928.43. I.G. Br. 12.

III. Respondent's Request And Statement Of The Case.

Respondent refutes the I.G.'s allegations and seeks dismissal of this case on several legal grounds. She also asserted at the hearing that (1) she either provided the services as claimed or (2) sincerely believed that she had the right to bill for services rendered to her patients over the telephone. Respondent also argues that, if I find that liability was proven by the I.G., the mitigating circumstances she proved should substantially reduce the amount of any penalties, assessments, and period of exclusion.

In addition to Respondent asserting that the I.G. did not prove his case, Respondent argues that: (1) the Medicaid HRVS Codes and Medicaid Physician's Manual were not adopted by the Hawaii Department of Human Services (DHS) and, therefore, were not binding on Respondent; (2) the I.G. is equitably estopped by reason of the Release Agreement between the State of Hawaii and Respondent; (3) the sanctions sought amount to double jeopardy; (4) there is no legal basis for bringing this case; and (5) the five year period of limitations bars the claims in issue in this case.

IV. Prehearing Motions.

Prior to the hearing, Respondent filed a motion to dismiss based on the doctrine of res judicata, collateral estoppel, and issue preclusion, a motion in limine, and briefs in support thereof. The I.G. filed responses and briefs in opposition to Respondent's motions. I issued a Ruling on April 18, 1989 denying Respondent's motion to dismiss and granting Respondent's motion in limine in part.

V. The Hearing.

A prehearing conference was held by telephone in this case on November 30, 1988, and a Prehearing Order and Notice of Hearing was issued on December 2, 1988, summarizing all matters discussed at the conference. A formal evidentiary trial-type hearing was held in Honolulu, Hawaii from May 8, 1989 through May 11, 1989. Both parties were represented by counsel at the hearing, with five witnesses testifying on behalf of the I.G. and six witnesses testifying on behalf of Respondent. Each of the parties filed two post-hearing briefs and proposed findings of fact and conclusions of law.[2]

VI. Dismissal Of Corporate Party.

The Notice of Determination also named Corazon C. Hobbs, M.D., Inc. as a party. However, this corporate entity no longer exists. Tr. 67, 861. Respondent moved to dismiss the corporate party. The I.G. consented to dismissing

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[2] Some of the proposed findings of facts and conclusions of law which the parties offered were rejected because they were not supported by the evidence, needed to be modified, or were not relevant.

the corporate party, and I, therefore, grant Respondent's Motion.

ISSUES

The issues are:

I. Liability.

1. Whether the I.G. is equitably estopped or otherwise barred in this case by the Release Agreement between the State of Hawaii and Respondent, or barred by the previously existing period of limitations in the Regulations.

2. Whether the I.G. proved that the 111 Medicaid services in issue "were not provided as claimed."

3. Whether the I.G. proved that Respondent "knew," "had reason to know," or "should have known" that the 111 Medicaid services at issue were not provided as claimed, in violation of the CMPL and Regulations.

II. The Amount of the Penalty, Assessment, and the Period of Exclusion.

1. Whether the I.G. proved the aggravating circumstances alleged.

2. Whether Respondent proved any circumstances that would justify reducing the amount of the penalties, the assessments, or the period of exclusion proposed by the I.G.

FINDINGS OF FACT AND CONCLUSIONS OF LAW [3]

Having considered the entire record, the arguments, and the submissions of the parties, and being advised fully herein, I make the following Findings of Fact and Conclusions of Law:

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[3] Any part of this Decision and Order preceding these Findings of Fact and Conclusions of Law which is obviously a finding of fact or conclusion of law is hereby incorporated into this section.

1. For the purposes of these proceedings, I have taken judicial notice of the statutes of the United States and the State of Hawaii, and the regulations of the Department of Health and Human Services (DHHS). J. Ex. 1/1.

2. This proceeding is governed by section 1128A of the Social Security Act (the Act), 42 U.S.C. 1320a-7a, and regulations promulgated thereunder, 42 C.F.R. Part 1003.100 et seq. J. Ex. 1/2.

3. The six-year statute of limitations provided by section 1128A(c)(1) of the Act is controlling in this case.

4. The I.G. is not barred from bringing this action by either the doctrine of equitable estoppel or the law of partnerships.

5. Respondent Corazon C. Hobbs, M.D., has practiced internal medicine in the Honolulu, Hawaii area since 1973, and entered private practice in 1977. Tr. 803-805.

6. Respondent signed an application to participate as a provider of Medicaid services in Hawaii on December 14, 1977. As a provider of services for the Medicaid program, Respondent was obligated to make herself aware of program requirements and to keep such records as necessary to disclose fully the extent of services provided. I.G. Ex. 148; Tr. 804, 805.

7. Respondent's earnings from the Medicaid program, and relative ranking in earnings among Medicaid internist-providers, during the years relevant to this case, are as follows:

1982	$90,402.33	Third
1983	$99,818.17	Fifth
1984	$76,560.04	Third
1985	$55,953.54	Ninth
1986	$60,046.55	Tenth
1987	$72,562.37	Eighth
1988	$56,567.87	Fourteenth

Tr. 350-355.

8. The number of internists in Hawaii who were Medicaid providers increased from 320 in 1982 to 450 in 1988. Tr. 355.

9. The Secretary of DHHS has delegated to the I.G. the authority to take action under section 1128A of the Act. J. Ex. 1/3.

10. The I.G. has redelegated to the Assistant I.G. for Investigations the authority to take action under section 1128A. J. Ex. 1/4.

11. The Assistant I.G. for Investigations has redelegated to the Deputy Assistant I.G. for the Civil Fraud Division the authority to take action under section 1128A of the Act. J. Ex. 1/5.

12. In a Notice dated July 29, 1988, the Deputy Assistant I.G. for the Civil Fraud Division, DHHS, pursuant to 42 C.F.R. 1003.105, properly notified Corazon Cadiz Hobbs, M.D. and Corazon Cadiz Hobbs, M.D., Inc. (Respondents), under section 1128 of the Act, of the proposed penalties, assessments, and period of exclusion. J. Ex. 1/6.

13. In January 1985, an investigation of Dr. Hobbs's billings was commenced by the Medicaid Fraud Control Unit of the Office of the Attorney General for the State of Hawaii. Tr. 603-605.

14. This investigation was initiated following a telephone call from an employee of Dr. Mojtaba Motlagh, a doctor who shared offices with Dr. Hobbs. Dr. Motlagh is the husband of Dr. Hobbs. Tr. 605, 736.

15. On February 21, 1985, a search warrant was executed in the offices of Dr. Hobbs and approximately 1500 medical records were seized. Tr. 608-609.

16. Among the medical records seized were the medical records for the 111 claims at issue in this case. Tr. 609.

17. On June 26, 1985, Dr. Hobbs was indicted by the State of Hawaii on 119 counts of filing false claims for services to Medicaid recipients and one count of Theft in the First Degree. J. Ex. 1/10.

18. On February 10, 1986, Dr. Hobbs pleaded nolo contendere to the Count of Theft in the First Degree referred to above. Acceptance of the plea was deferred in accordance with an Order Granting Motion for Deferred Acceptance of nolo contendere plea. The State of Hawaii

nolle prosequied "with prejudice" the 119 counts of filing false claims to Medicaid recipients. J. Ex. 1/11.

19. As a result of the plea referred to above, Dr. Hobbs was obligated by the court to serve 500 hours of community service. In addition, pursuant to the Release Agreement with the State of Hawaii, Respondent paid $1,123.61 in restitution and $1,122.00 in costs. J. Ex. 1/12.

20. On July 29, 1988, the state court dismissed the aforementioned charge of Theft in the First Degree. J. Ex. 1/13.

21. Under the facts of this case, Respondent has not been convicted of any Medicaid fraud or theft in connection with claims submitted to the Medicaid fiscal agent in the State of Hawaii. J. Ex. 1/14.

22. Respondent Corazon Cadiz Hobbs, M.D., Inc., the corporate party, is dismissed as a party.

23. The Hawaii Department of Human Services (DHS) is the designated state agency responsible for administering the Medicaid program. DHS was previously known as the Department of Social Services and Housing (DSSH). Tr. 293.

24. At all times pertinent to this action, Hawaii Medical Service Association (HMSA) was the designated fiscal agent for the State of Hawaii Medicaid program. J. Ex. 1/7.

25. HMSA is charged with processing and paying Medicaid claims for reimbursement in Hawaii, and is also a private insurance carrier and a member of Blue Cross/Blue Shield. When Medicare beneficiaries are involved, Medicaid pays as a secondary insurer for copayments and deductibles. Tr. 94-96, 292-293.

26. In 1970, the Hawaii Medicaid program adopted the 1970 Relative Value Studies (HRVS) of the Hawaii Medical Association. Tr. 297-298.

27. The HRVS was not formally adopted as a regulation by DHS, but DHS did instruct HMSA to use the HRVS codes. Tr. 299-300, 306-307, 311.

28. The Provider Agreement signed by Respondent obligated her to use the correct HRVS codes in billing Medicaid.

29. The HRVS contains certain codes and descriptions of services signified by code numbers. I.G. Ex. 114.

30. The utilization of these codes allowed claims to be processed by code number and replaced the use of long verbal descriptions of services. Tr. 299-300.

31. From 1970 through 1985, there were no direct changes in the HRVS to the definitions of procedure codes 90030, 90050 or 90060. Tr. 323-323.

32. Beginning in the 1970's, newsletters containing information on the types of services covered under the Medicaid program, and (2) billing instructions were sent to providers every two to three months. These newsletters were written by HMSA and approved by DHS. Tr. 344-345.

33. On August 20, 1981, HMSA sent out a Medicaid Newsletter which stated that telephone calls were not covered under the Medicaid program. I.G. Ex. 147/5; Tr. 343.

34. This newsletter was sent to all providers, including Respondent, who were participating in the Medicaid program at that time. Tr. 343.

35. In January 1983, the "Medicaid Physician Manual" (Manual) produced by HMSA and approved by DHS, was sent to all physicians in Hawaii who were Medicaid providers at that time. Tr. 318.

36. A copy of the January 1983 Manual was sent to Dr. Hobbs and she received it on February 3, 1983. I.G. Ex. 149; Tr. 278, 338, 339, 535, 566.

37. The 1983 Manual repeated the earlier directive to providers that telephone calls, including long-distance calls, were not recognized as valid medical services and should not be billed to the Medicaid program or the patient. I.G. Ex. 115/3.

38. None of the Manuals have ever been adopted by any rule or regulation under the Hawaii Administrative Procedure Act, Hawaii Revised Statutes section 91-3 et seq. J. Ex. 3/4.

39. The Medicaid Physician's Manual and the HRVS codes do not have to be formally adopted under the Hawaii Administrative Procedure Act to bind providers.

40. Dr. Corazon C. Hobbs submitted or caused to be submitted to HMSA the 111 claims for reimbursement listed in the schedule that is attached to the I.G.'s Notice (Schedule of Claims). J. Ex. 1/8.

41. The amounts claimed to HMSA, the amounts paid by HMSA, and the date of service and HRVS Codes listed for the 111 claims in issue are correctly stated in I.G.'s Exhibit 121. J. Ex. 1/9.

42. The total amount claimed by Dr. Hobbs for the 111 claims presented to the Medicaid program was $2026.02. Of this amount, $1030.22 was paid by HMSA to Dr. Hobbs. I.G. Ex. 121.

43. The claims in issue were presented or caused to be presented on three different types of forms -- Form 9, HCFA 1490, and HCFA 1500. I.G. Ex. 1.1-111.1.

44. Claims 1, 2, 12, 13, 18-21, and 45-47 are on Form 9s. I.G. Ex. 1.1, 2.1, 12.1, 13.1, 18.1-21.1, 45.1-47.1.

45. Claims 3-11, 27-44, 77, and 95-101 are on HCFA 1490 forms. I.G. Ex. 3.1-11.1, 27.1-44.1, 77.1, 95.1-101.1.

46. Claims 14-17, 22-26, 48-76, 78-94, and 102-111 are on HCFA 1500 forms. I.G. Ex. 14.1-17.1, 22.1-26.1, 48.1-76.1, 78.1-94.1, 102.1-111.1.

47. Information in regard to the type of service rendered and location of the service appears in different locations on these forms. I.G. Ex. 1.1-111.1.

48. On claim Form 9, the information as to the service rendered by Respondent was placed by her or her staff on a line where the words "OFFICE VISIT" were printed in capital letters. I.G. Ex. 1.1.

49. On the other two types of forms submitted by Respondent, the words "OFFICE VISIT" was handwritten by her or her staff in the description column on the front of the claim form. I.G. Ex. 3.1, 14.1.

50. Of the 35 claims filed on HCFA 1490 forms, 32 have the letter "O", placed on the form by Respondent or her

staff, which the form states as meaning the place of service as "Doctor's Office". I.G. Ex. 3.1-11.1, 27.1-44.1, 77.1, 95.1-101.1.

51. All of the 65 claims filed on HCFA 1500 forms have the number "3", placed on the form by Respondent or her staff, which the form states as meaning the place of service as "Doctor's Office". I.G. Ex. 14.1-17.1, 22.1-26.1, 48.1-76.1, 78.1-94.1, 102.1-111.1.

52. Ninety-seven of the 111 claims contain a representation that the services were rendered in the office of Dr. Hobbs. See FFCL 50 and 51.

53. The following codes in the HRVS pertain to "Office Visit:"

> a. 90030 is described as, "Minimal service (e.g. injection, immunization, minimal dressing)..."
>
> b. 90050 is described as, "Limited examination, evaluation, and/or treatment...."
>
> c. 90060 is described as, "Intermediate examination, evaluation and/or treatment, same or new illness."

I.G. Ex. 114/2.

54. Seventy-six of the 111 claims have one of the HRVS codes of 90030, 90050, or 90060, which the HRVS designates as "office visit" codes, written on them. The other 21 claims do not have a code written on them, but do have the words "office visit" written or printed on the claims. I.G. Ex. 1.1, 2.1, 12.1-26.1, 45.1-76.1, 78.1-94.1, 102.1-111.1.

55. Shanelle Baxa worked as a receptionist and secretary for Dr. Hobbs, in Hawaii, from March 1982 until February 1985. Shanelle Baxa's legal name at the time she worked for Dr. Hobbs was Ninfa D. Cadiz. Tr. 23-25.

56. Narcissa Ranchez worked as a medical assistant for Dr. Hobbs, in Hawaii, from October 1982 to October 1984. Tr. 545.

57. During Ms. Baxa's and Ms. Ranchez's employment with Dr. Hobbs, there was a standard procedure for office visits and a procedure for handling prescription refills by telephone. Tr. 27, 545.

58. The standard procedure when a patient came to the office was to sign them in at the receptionist's desk, pull the patient's medical chart, check their vital signs (blood pressure, weight, and temperature), and write the patient's vital signs and chief complaint in the medical chart. The patients were then escorted to an examining room and their medical chart was placed in a box on the door to the room. Tr. 27, 28, 267, 545, 546.

59. The vital signs and chief complaint were not taken on some occasions when an emergency patient or a child was involved. These were exceptions to the standard procedure used in Dr. Hobbs' office, and were rare. Tr. 28, 273, 547, 548.

60. When Dr. Hobbs saw or examined a patient, she would write the progress notes and prescription in the medical chart, except on rare occasions when she would ask either Ms. Baxa or Ms. Ranchez to write a prescription in the patient's medical chart. Tr. 73, 539, 549.

61. It was standard office procedure in Dr. Hobb's office, when a patient telephoned for a prescription refill, to:

a. request the patient's name, medication, and the name of the pharmacy;

b. pull the patient's medical chart;

c. obtain approval from Dr. Hobbs;

d. telephone the pharmacy with the prescription;

e. enter the prescription on the medical chart; and

f. place the chart on the medical assistant's desk for billing.

Tr. 32, 33, 34, 43, 538.

62. A "p" was sometimes written beside the entry in the medical chart to indicate a prescription Tr. 54.

63. In the cases where a doctor was covering for Dr. Hobbs, only the covering doctor could write in the medical record, regardless of whether it was an office visit or a telephone prescription refill. Tr. 83.

64. During Ms. Baxa's employment, there were occasions when Dr. Hobbs answered the telephone and handled prescription refills. Tr. 32.

65. In reviewing the 111 claims and the corresponding medical records, the following criteria determine whether a claim billed as a claim for an office visit was, in fact, a claim for a telephone prescription refill:

a. the medical record entry is for a prescription, has the letter "p" (prescription) written beside it, and does not contain vital signs or a chief complaint ("cc");

b. the medical record indicates that this same medicine had recently been prescribed; and

c. the medical record entry is in the handwriting of an employee or a covering doctor, instead of Dr. Hobbs.

66. The medical record entries which correspond to 95 claims have no vital signs, no chief complaint, and are in the handwriting of an employee. I.G. Ex. 1.2-3.2, 5.2-12.2, 14.2-18.2, 20.2-24.2, 26.2-30.2, 32.2-44.2, 47.2, 48.2, 50.2-58.2, 60.2-62.2, 64.2-67.2, 69.2-85.2, 87.2-100.2, 102.2-106.2, 109.2-110.2; Tr. 167, 549-551.

67. The medical record entries which correspond to four claims have no vital signs, no chief complaint, and are in the handwriting of a covering doctor. I.G. Ex. 31.2, 49.2, 68.2, 101.2; Tr. 83.

68. The medical record entries which correspond to five claims have a chief complaint, but no vital signs and are in the handwriting of an employee. I.G. Ex. 25.2, 45.2, 46.2, 86.2, 107.2; Tr. 79, 85, 92, 104.

69. The medical record entries which correspond to three claims have no vital signs, no chief complaint, and are in the handwriting of Dr. Hobbs. I.G. Ex. 13.2, 59.2, 63.2; Tr. 76, 87, 89.

70. The medical record entries which correspond to three claims have a chief complaint, but no vital signs, and are in the handwriting of Dr. Hobbs. I.G. Ex. 19.2, 108.2, 111.2; Tr. 77, 104, 105.

71. The medical record entry which corresponds to claim four has no vital signs and no chief complaint. The handwriting for this entry was not identified. I.G. Ex. 4.2.

72. No vital signs are present on any of the medical charts which correspond to the 111 claims in issue. I.G. Ex. 1.2-111.2.

73. The medical records which correspond to 47 claims have the letter "p" written beside the entry on the medical chart. I.G. Ex. 1.2, 2.2, 4.2-8.2, 11.2, 12.2, 14.2, 18.2-21.2, 26.2-30.2, 36.2, 39.2-42.2, 45.2, 48.2, 49.2, 56.2, 58.2, 64.2, 67.2, 69.2, 71.2, 73.2, 75.2, 78.2, 80.2, 82.2, 83.2, 85.2, 86.2, 89.2, 90.2, 94.2, 96.2, 97.2, 100.2, 102.2, 103.2, 106.2-109.2; FFCL 62.

74. Of the 111 claims in issue, only eight have a "cc," meaning chief complaint, listed on the corresponding medical chart. I.G. Ex. 19.2, 25.2, 45.2, 46.2, 86.2, 107.2, 108.2.

75. The medical record entries which correspond to claims 13, 59, and 63 indicate that the medicine prescribed on that occasion had been recently prescribed for those same patients. I.G. Ex. 13.2, 59.2, 63.2; Tr. 76-77, 87, 89.

76. Of the 111 claims in issue, the medical record entry for all claims, except 13, 19, 31, 49, 59, 63, 68, 101, 108, and 111 are in the handwriting of an employee of Dr. Hobbs. I.G. Ex. 1.1-12.2, 14.2-18.2, 20.2-30.2, 32.2-48.2, 50.2-62.2, 64.2-67.2, 69.2-100.2, 102.2-107.2, 109.2-110.2.

77. For claims 31, 49, 68 and 101, the medical record entry is in the handwriting of doctors who covered Dr. Hobbs' patients for her. I.G. Ex. 31.2, 49.2, 68.2, 101.2.

78. The medical record entry for claim 31 is in the handwriting of a covering doctor, contains no vital signs or chief complaint, and contains a prescription entry. I.G. Ex. 31.2; Tr. 80.

79. The medical record entry for claim 49 is in the handwriting of a covering doctor and was a prescription refill for a lotion. I.G. Ex. 49.2; Tr. 85, 86.

80. The medical record entries for claims 68 and 101 are in the handwriting of a covering doctor, contain no vital signs, and were for prescriptions which had been recently prescribed by Dr. Hobbs. Tr. 101-103; I.G. Ex. 68.2, 101.2.

81. During their employment with Dr. Hobbs, Ms. Baxa or Ms. Ranchez would usually fill out the claim forms, although a sister of Dr. Hobbs would sometimes assist in filling out forms after office hours. Tr. 26.

82. The person preparing the claim forms would work from the medical records placed on the medical assistant's desk. A claim form would be filled out, clipped to the medical chart, and given to Dr. Hobbs for her review and signature. A double hash mark was made on the left side of the medical chart entry to indicate it had been billed. Tr. 45, 55, 274, 552.

83. Dr. Hobbs admitted that she and her staff had billed Medicaid for prescription refills called in over the telephone since the beginning of her private practice in 1977. Tr. 43, 44, 553, 867, 868.

84. When an employee did not know the appropriate code for a claim, they asked Dr. Hobbs. Tr. 121, 134, 136, 285.

85. During Ms. Baxa's employment, Dr. Hobbs sometimes wrote the HRVS code in the margin of the medical record. I.G. Ex. 15.2, 23.2, 119.2; Tr. 108.

86. Dr. Hobbs had a policy of using code 90060 for every new illness of a patient. Tr. 555, 556, 874, 879.

87. Ten of the 111 claims in issue were billed using the code 90060, and one using the code 90050. I.G. Ex. 121.

88. During Ms. Baxa's employment, Dr. Hobbs returned claim forms which had been filled out by one of her employees because she did not agree with the code used by the employee. Tr. 276, 596.

89. Fifty-nine of the claims were on HCFA 1500 forms containing a certification. I.G. Ex. 113.

90. Notice is given to a provider on the reverse side of the HCFA 1500 form to refer to the HMSA Medicaid Physician's Manual for complete instructions. I.G. Ex. 112.

91. On the reverse side of the 59 HCFA claim forms, Block 25 contained a "Provider Statement" which:

a. certified that the information on the form was true, accurate, and complete;

b. acknowledged that Dr. Hobbs understood that payment of the claim would be from federal and state funds; and

c. advised her that any false claims, statements, documents, or concealment of material facts, would subject her to prosecution under federal or state laws.

I.G. Ex. 112.

92. The Provider Statement on these HCFA forms further contained a requirement that Dr. Hobbs keep such records as necessary to disclose fully the extent of services provided to a patient. I.G. Ex. 112.

93. During Ms. Baxa's employment, there were occasions when Dr. Hobbs was questioned by her employees about the billing of telephone prescription refills to Medicaid. Tr. 37, 38.

94. During Ms. Ranchez's employment, there were instances when Dr. Hobbs told her staff to retrieve a patient's medical record from the patient cabinet file and to bill Medicaid for a telephone prescription refill. Tr. 275, 553, 554.

95. In April 1985, following the execution of the search warrant by the Hawaii State Medicaid Fraud Control Unit, Dr. Hobbs stopped billing for prescription refills by telephone. Tr. 885.

96. The I.G. proved that claims 1-18, 20-107, 109, and 110 were for prescription refills taken over the telephone, and were not for office visits.

97. The I.G. proved that Dr. Hobbs knew that the Medicaid services for 94 claims were not provided as claimed. I.G. Ex. 3.1, 4.1, 6.1-11.1, 14.1-17.1, 22.1-38.1, 40.1, 42.1-44.1, 48.1-51.1, 53.1-107.1, 109.1, 110.1.

98. The I.G. proved that Dr. Hobbs should have known that the Medicaid services listed on 108 claims were not provided as claimed.

99. The I.G. proved that Dr. Hobbs had reason to know that the Medicaid services listed on 108 claims were not provided as claimed.

100. The I.G. did not prove that claims 19, 108, and 111 were not for office visits.

101. The I.G. did not prove that Dr. Hobbs should have known, had reason to know, or knew that the Medicaid services listed as claims 19, 108, and 111 were not provided as claimed.

102. The amount of penalties and assessments, and the length of exclusion from participation in the various medical programs, is to be determined in a CMPL case by reviewing:

a. the nature and circumstances under which the requests for payment were made;

b. the degree of a respondent's culpability;

c. the existence of prior offenses;

d. Respondent's financial condition; and

e. any other matters that justice may require.

42 C.F.R. 1003.106, 1003.107.

103. The I.G. proved that it is an aggravating circumstance that the claims presented by Dr. Hobbs were for services provided over a lengthy period of time.

104. The I.G. proved that it is an aggravating circumstance that there were a substantial number of claims involved in this case.

105. The I.G. proved that the amount claimed for the services at issue was substantial.

106. The I.G. proved that there was a pattern to the claims submitted by Respondent.

107. The I.G. proved that it is an aggravating circumstance that Dr. Hobbs knew that the some of the claims for services were not provided as claimed.

108. The I.G. did not prove that there were other factors to be considered.

109. The I.G. did not prove all of the aggravating circumstances which he alleged.

110. The I.G. did not prove that at any time prior to the presentment of an actionable claim, Respondent had been held liable for criminal, civil, or administrative sanctions in connection with a program of reimbursement for medical services.

111. Dr. Hobbs proved that the services billed were all of the same type.

112. Dr. Hobbs proved that circumstances exist which would justify a small reduction in the amount of penalties and a reduction in the period of the exclusion imposed. Dr. Hobbs is a valuable resource to her community. Although the telephone prescription refills were not office visits and not reimbursable, Dr. Hobbs was concerned about her patients and did render some service to the patients in this case. Tr. 715, 716, 724, 728, 863.

113. Dr. Hobbs did not prove that the services were provided within a short period of time.

114. Dr. Hobbs did not prove that 108 claims for services were the result of an unintentional and unrecognized error in the process by which she presented claims.

115. Dr. Hobbs did not prove that the imposition of the proposed penalties and assessments, without reduction, would jeopardize her ability to continue as a health care provider.

116. The appropriate amount of civil monetary penalties in this case is $49,000.00, the appropriate amount of assessments is $2,797.81, and the appropriate period of exclusion is two years.

DISCUSSION

I. The I.G. is Not Equitably Estopped and the Six-Year Statute Of Limitations Applies In This Case.

Respondent asserts that we need not deal with the merits of this case because this proceeding is barred by the Release Agreement she entered into with the State of Hawaii in connection with the resolution of the criminal charges brought against her. She argues that the doctrine of equitable estoppel and principles of the law of partnerships are applicable to this agreement. R. Ex. 7; R. Br. 3, 10-13. There is no merit to Respondent's arguments. The doctrine of equitable estoppel does not apply in this case. There has been no proof of any misstatement or affirmative misconduct on the part of any United States Government official, and no showing of detrimental reliance. Heckler v. Community Health Services of Crawford County, 467 U.S. 51 (1989); Wagner v. Director Federal Emergency Management Agency, 847 F.2d 515, 519 (9th Cir. 1988).

Furthermore, the relationship of the United States and the states in the administration of the Medicaid program is not a legal partnership. Harris v. McRae, 448 U.S. 297, 309 (1980); Rowley on Partnerships (1960), pp. 89-93.

Respondent also asserts that most of the 111 claims in issue are time-barred because the previously existing five-year period of limitations in the Regulations controls in this case, rather than the six-year statute of limitations enacted in 1987.

On August 18, 1987, the CMPL was amended to include a six-year statute of limitations. Prior to this date, there was no statute of limitations expressly provided in the CMPL itself, but a five-year period of limitations was provided for in the Regulations. Congress specified that the six-year statute of limitations added to the CMPL would apply to all actions initiated by the I.G. after September 1, 1987.

This action was initiated after September 1, 1987, and all the claims in issue were presented within six years preceding the I.G.'s Notice. Accordingly, Congress having intended the new six-year statute of limitations to apply in all CMPL actions initiated after September 1, 1987, I conclude that the six-year statute of limitations

applies to this action. Inspector General v. Donald O. Bernstein, D.O., DAB Docket No. C-40 (1989).

II. There Are Only Two Elements Of Liability in Dispute in This Case.

The CMPL provides that any person who presents a false or improper claim for Medicare or Medicaid reimbursement shall be subject to (1) a civil money penalty of not more than $2,000 for each item or service, (2) an assessment of not more than twice the amount claimed for each item or service, and (3) an exclusion from participating in the Medicare and Medicaid programs.

The I.G. has the burden of proving by a preponderance of the evidence all elements of liability under the CMPL and Regulations for each claim in issue. The I.G. must prove that (1) a "claim" (2) was "presented or caused to be presented" (3) by a respondent (4) to the Medicare or Medicaid programs (5) for "a medical or other item or service" (6) when he or she "knew", "had reason to know", or "should have known" (7) that the items or services in issue were "not provided as claimed." CMPL 1320a-7a(1)(A)(B)(C); Regulations 1003.102(a)(1).

The only two elements of liability in dispute in this case are: (1) whether Respondent provided the services "as claimed" and, if not, (2) whether she "knew," "had reason to know" or "should have known" that the services claimed were "not provided as claimed."

III. The I.G. Proved That The Services Listed on 108 of the 111 Claims Were Not Provided As Claimed.

During the period in issue, Medicaid paid for "office visits," but did not pay for medical services provided by telephone. Telephone calls were not considered valid medical services. Tr. 348; I.G. Ex. 115/3. Respondent admitted that she billed Medicaid for filling or refilling prescriptions by telephone and had done so from the inception of her private practice of internal medicine in 1977 until Medicaid executed its search warrant in 1985. Tr. 43, 44, 553, 867, 868, 885.

The word "visit" is defined "to go to see (as a physician or dentist) for professional services." Webster's Third New International Dictionary (1976).

Accordingly, the term "office visit" means to physically enter an office for a visit. Respondent conceded during her cross-examination that even she views the concept of an "office visit" as physical presence in the office.

> Question: How many patients would visit your office on the average day (during the time period 1982 to 1984)?
>
> Answer: . . . about maybe 50, 60.
>
> Question: And you didn't include people who called in on the phone in that figure because visiting an office means physically coming to an office doesn't it? Isn't that what you were thinking just now?
>
> Answer: Yes.

Tr. 863-864.

For the period in issue, Respondent's standard office procedure for handling patients who actually came into the office was as follows: Upon entering the office, the patient was asked to write his or her name on a sign-in sheet.[5] The medical assistant would then pull that patient's medical chart from the file cabinet, summon the patient, take the patient's blood pressure, temperature, and weight, and record the vital signs and the patient's chief complaint. The patient then would be led into one of the examining rooms, and the medical record would be put in a box on the door of that examining room. Tr. 27, 28, 267, 545, 546. Thus, I used these three criteria to determine whether a patient had been present in Dr. Hobbs' office: the recordation of the vital signs and chief complaint, and whether Dr. Hobbs herself or one of her staff members wrote the entry in the medical record.

The medical records and the testimony of three former employees establish that, with respect to 108 of the 111 claims in issue, the services for which Respondent billed Medicaid were solely for the filling or refilling of prescriptions by telephone. FFCL 96. The I.G. did not prove that claims 19, 108, and 111 were not for an "office visit" as claimed because Dr. Hobbs wrote a chief

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[5] The sign-in sheets were used to establish the order in which patients were examined. They had no other purpose and were not retained as office records. Tr. 848.

complaint on the medical records corresponding to these claims. FFCL 101.

The evidence shows that the criteria for an office visit were not met in these 108 instances.

Three former employees who worked for Respondent during 1982-1984 testified.[6] I found that they testified convincingly, and provided credible evidence, regarding the practices in Respondent's office. I reject Respondent's contention that their testimony was "incredible and riddled with exceptions". Ms. Shanelle Baxa worked in the office from March 23, 1982 to February 1985 as a secretary and receptionist. Tr. 24, 25. Ms. Narcissa Ranchez was employed by Dr. Hobbs as a medical assistant from October 1982 through October 1984. Tr. 545. Ms. Trinidad Tugauen replaced Ms. Ranchez as a medical assistant, and worked for Dr. Hobbs from October 1, 1984 through October 1987. Tr. 264, 265, 270.

Ms. Baxa testified that exceptions to taking the vital signs and chief complaint occurred "not too often." Tr. 28, 31. Ms. Ranchez testified that all but approximately 10 percent of the patients physically coming into the office would have vital signs taken. Tr. 547, 548. In other words, about 90 percent of the patients would have vital signs taken. Ms. Tugauen testified that 95 to 96 percent of the time vital signs were taken for patients visiting the office. Tr. 273.

Ms. Ranchez also testified that the two principal exceptions to taking down vital signs occurred with patients with an emergency condition, or a patient who had a very recent visit (within 2 weeks). Tr. 546. However, even if a patient came in with an emergency, an indication of the chief complaint would be put in the medical record. Tr. 142, 290, 547, 548. Respondent did not credibly rebut this testimony.

When Respondent saw the patient, it was she who wrote the progress notes and prescription (if any) in the medical record herself. Tr. 73. Ms. Baxa testified that "not too often" would Ms. Baxa write a prescription in the medical record for someone who came into the office. Tr. 539. Likewise, Ms. Ranchez testified that it would

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[6] Throughout their testimony, Respondent's counsel objected on relevancy and other grounds. I overruled his objections and I sustain those rulings now.

be "rare" for someone other than Respondent to write a prescription in the medical record for a patient who came into the office. Tr. 549.

The standard office procedure for handling prescription refills by telephone was very different from the procedure used for patients who came into the office. When a patient would telephone the office for a prescription refill, the person who answered the telephone would obtain the following information: patient name, medication, and pharmacy. The person would then pull the medical chart for that patient, obtain approval from Respondent to authorize a refill of the prescription (except where Dr. Hobbs herself answered the telephone), and telephone the prescription to a pharmacy. Tr. 32, 33, 43. The person would then enter the prescription on the medical record, and place the medical record on the medical assistant's desk (sometimes called the "billing table") for preparation of a claim. This practice was followed throughout the employment of Ms. Baxa. Tr. 34. The same procedure was attested to by Ms. Ranchez. Tr. 538.

In conclusion, the documentary evidence in the record, corroborated by the testimony of Ms. Baxa, Ms. Ranchez, and Ms. Tugauen, proves that "office visit" services were not rendered as claimed on 108 of the 111 claims in issue. Respondent admitted that she submitted or caused to be submitted all 111 claims. J. Ex. 1/8. The term "office visit" appears in writing or in print on all 111 claims. Thus, the I.G. proved that 108 claims which list "office visit" services as being rendered were for services other than an "office visit" and that "office visit" services were "not provided as claimed".

IV. The I.G. Proved That Respondent "Knew," "Had Reason To Know" or "Should Have Known" The Services Claimed Were Not Provided As Claimed.

The current standard of knowledge in the CMPL required for liability to attach is that a respondent "knows or should know" that an item or service is not provided as claimed. [7] The statute sweeps within its ambit not only

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[7] The standard of knowledge in the CMPL prior to December 22, 1987 was that a respondent "know" or had "reason to know." The "should know" standard became law

(continued...)

the knowing, but the negligent. . . ." 48 Fed. Reg. 38827, 38831 (Aug. 26, 1983).

A. The I.G. Proved That Respondent "Had Reason To Know" That 108 of the 111 Claims in Issue Were Not For "Office Visits" As Claimed.

The "reason to know" standard employs the "reasonable person" (objective knowledge) concept. The "reason to know" standard attaches where a respondent has sufficient information to create an obligation to investigate and find out whether certain services are billable under the Medicare or Medicaid programs. See, The Inspector General v. George A. Kern, DAB Docket No. C-25 at p. 6 (1987); and the Restatement of Torts (2d) (at section 12) (1965).

Thus, to the extent that Respondent submitted improper claims which she could have known were improper had she investigated, she is liable under the CMPL for presenting claims in which the services were "not provided as claimed." She is liable under this standard whether or not her awareness at the time she signed or submitted a claim would support a finding that she knew the services were not provided as claimed.

1. Respondent Had A Duty To Investigate And Learn The Requirements For Submitting Claims.

The first major category of duties for every provider of services arises by reason of a contractual arrangement between the provider and the Medicaid program. Every medical provider must sign a Provider Agreement in order to participate in the Medicaid program.

Respondent signed her Provider Agreement in 1977 and agreed to make herself aware of program requirements and

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[7] (...continued)
on December 22, 1987, as a result of an amendment to the CMPL, enacted by section 4118(e) of the Omnibus Budget Reconciliation Act (OBRA) of 1987, Pub. L. 100-203. The legislation stated that the amendment would "apply to activities occurring before, on, or after the date of [OBRA's] enactment . . ." Section 4118(e)(3) of OBRA. See, The Inspector General v. Dean G. Hume, DAB Docket No. C-50 at pp. 18-21 (1989).

to keep such records as necessary to disclose fully the extent of services provided. FFCL 28.

The second major category of duties arise by reason of Medicaid instructions to all Medicaid providers. HMSA issued instructions to medical providers with regard to what items and services the Medicaid program would reimburse, and which items and services were not reimbursable (in the form of a Provider Manual -- which is called the "Medicaid Physician Manual" in Hawaii -- and newsletters).

In January 1983, the "Medicaid Physician Manual" was produced by HMSA, reviewed and commented upon by DHS, and published with the approval and on the instructions of DHS. I.G. Ex. 115, Tr. 317, 333, 334. Respondent received a copy of the Manual on February 3, 1983.[8] FFCL 36. The Manual stated explicitly:

> Telephone calls - excluded. Telephone calls, including long-distance calls, are not recognized as valid medical services and should not be billed to the Medicaid program or the patient.

I.G. Ex. 115/3.

Earlier, on August 20, 1981 (prior to all of the claims in issue) this same policy was stated in a Medicaid Newsletter: "Telephone calls are not covered under the Medicaid program." I.G. Ex. 147/5. In general, these newsletters were sent out every two to three months starting in the 1970's. Tr. 344, 345. As with the other documents mentioned above, the newsletters were written

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[8] Due to the importance of the Medicaid Physician Manual, HMSA requested providers to fill out a receipt for the document and return it to HMSA. Tr. 338. A receipt for the Medicaid Physician Manual was located in the HMSA file for Corazon C. Hobbs, M.D., and was admitted into evidence as I.G. Ex. 149. Tr. 339. The receipt, which was dated February 3, 1983, bares a signature which was identified as the Respondent's signature by three of her former employees. Tr. 278, 535, and 566. The lay identification of the Respondent's handwriting was allowed into evidence under Rule 901(b)(2) of the Federal Rules of Evidence. See, U.S. v. Dreitzler, 577 F.2d 539 (9th Cir. 1978), cert. denied, 440 U.S. 921 (1979).

by HMSA and sent to DHS for the agency's approval. Tr. 345.

Procedure codes are a substitute for language on the claims. Code numbers are also relevant in determining whether Respondent misrepresented the services she provided. These codes, which must be followed by medical providers, are communicated to them through the Manual, newsletters, and memoranda sent to them by HMSA with the prior approval of DHS. Tr. 27, 295, 332.[9] The term "office visit" appears on each of the 111 claims in issue. FFCL 48, 49. The procedure codes listed in the Manual for the services described as "office visit" are listed on 76 of the claims in issue. FFCL 54.

2. Fifty-Nine Claims Have Certifications of Truth and Accuracy.

I held in Kern, supra (at pp. 60-62), that the duty to investigate springs from the certifications of truth and accuracy on the claim form itself. Fifty-nine of the claims at issue in this case were accompanied by such a certification. I.G. Ex. 112, 113. Thus, in addition to the duty to investigate generated by the Provider Agreement, the Manual, newsletters, and the terms and codes used and written by Respondent or her staff on the claim, Respondent was also made aware of her duty to investigate by the certification statement on these 59 claims.

I find and conclude that Respondent is liable under the CMPL for 108 claims that were not provided as claimed because of her duty to investigate and assure that these claims were proper. This does not contradict my finding that she actually knew that 94 of the claims were improper (discussed in C, infra).

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[9] I am not persuaded by Respondent's arguments that because the HRVS codes and Medicaid Physician's Manual were not formally adopted by the State of Hawaii pursuant to the Administrative Procedure Act, they are not binding on Respondent. United States v. Larm, 824 F. 2d 784 (9th Cir. 1987).

B. The I.G. Proved That Respondent Should Have Known That 108 Of The 111 Claims In Issue Were Not For "Office Visits" as claimed.

The "should know" standard is quite similar to the "reason to know" standard, except that the duty to inquire (the duty to ascertain the truth and accuracy of a claim) exists at all times and does not require any special circumstances to bring attention to the duty. The Restatement of Torts (2d) (at section 12) states:

> The words "should know" are used throughout the Restatement of this Subject to denote the fact that a person of reasonable prudence and intelligence or of the superior intelligence of the actor would ascertain the fact in question in the performance of this duty to another, or would govern his conduct upon the assumption that such fact exists.

In enacting the "should know" amendment in 1987, Congress indicated in the legislative history that the legislation was a clarification of the existing standard and that the "should know" standard of knowledge placed on Medicaid and Medicare providers the duty to ascertain the truth and accuracy of claims submitted by them:

> Providers who bill the Medicare, Medicaid and MCH programs have an affirmative duty to ensure that the claims for payment which they submit, or which are submitted on their behalf by billing clerks or other employees, are true and accurate representations of the items or services actually provided.

H. Rep. No. 100-391, 100 Cong., 2d Sess., pp. 533-535 (1987).

Respondent argued that "her evidence was that other physicians in the community don't pay attention to the billing details, read the Provider's Manual, nor read the reverse side of the claims forms in order to become aware of all of the intricate details of what is compensable and what is not." R. Br. 5. She also argued that the Medicaid rules were ambiguous and that, accordingly, the claims in issue should be viewed as a simple mistake. R. Br. 7.

I am not persuaded by these arguments. The "should know" standard includes reckless disregard for the consequences of a person's acts and simple negligence in preparing, presenting, or in supervising the preparation and

presentation of claims. Mayers v. U.S. Dept. of Health and Human Services, 806 F.2d 995 (11th Cir. 1986), cert. denied, 484 U.S. 822 (1987). Respondent was obliged to pay attention to her billing, read the Manual and bulletins, and resolve any ambiguities before submitting claims which were not proper. Her submission of improper claims which she should have known were improper makes her liable, and she is no less liable if she refused to inform herself adequately. Also, Respondent's characterization of her actions as a "simple mistake" would have some validity if she had written "telephone prescription refill" on the claim, but instead she used the words and codes for an "office visit." Thus, I find and conclude that Respondent is liable on 108 claims.

C. The I.G. Proved That Respondent "Knew" That 94 of the 111 Claims In Issue Were Not Provided As Claimed.

The I.G. established liability in this case under the "reason to know" and "should have known" standards of knowledge. Culpability under these is not as great as the "knows" standard. It should be noted, however, that in 94 of the 108 cases where liability was established, the I.G. also proved that Respondent had actual knowledge.

Respondent's actions demonstrate that she had the requisite degree of awareness to constitute conscious knowledge in 94 instances where she was claiming reimbursements as an "office visit" for services that were not an "office visit". As I stated in The Inspector General v. Jimmy Paul Scott, DAB Docket No. C-15 at p. 27 (1986), it was decided that Congress, in using the term "knows" and the drafters of the Regulations in using the term "knew," were referring to conscious knowledge of a fact (or subjective knowledge).

Respondent personally signed the 94 claims in question. On 32 of the claims, a "3" appears, meaning that the claim was for an "office visit" in the doctor's office. FFCL 50. On the remaining 65 claims, a handwritten "O" appears, meaning that the claim was for an "office visit in the doctor's office." FFCL 50, 51. (Of these 65 claims, three have been eliminated. I determined that the I.G. did not prove that two of these 65 claims were not for office visits. I.G. Ex. 108.1, 111.1. The I.G. did not prove that Respondent personally signed the third claim. I.G. Ex. 52.1) In addition, all 94 claims where I determined she "knew" have the words "office visit" printed or handwritten on them. Thus, Respondent knew

she was claiming reimbursements for an "office visit in the doctor's office." The information on the medical records which were attached to the claims when Respondent signed them did not contain the information which would have been there if the patient had been physically present in the office for the billed service. It was office procedure to clip the claim to the pertinent medical record when Respondent reviewed and signed the claims. Tr. 45. The medical records should have contained both vital signs and the chief complaint, but they did not. Thus, Respondent "knew" that an "office visit" had not occurred and that the patient was not seen in the doctor's office. Even though she "knew" that only telephone services had been provided by her, she claimed reimbursement for office visits because she "thought that every service you give should be reimbursable." Tr. 810.

V. The Appropriate Amount of the Penalty, Assessment, and Exclusion is not arrived at by Formula.

A. The ALJ Must Consider the Aggravating and Mitigating Factors and Other Considerations.

The CMPL and Regulations require the ALJ to consider aggravating and mitigating circumstances in deciding the appropriate amount of the sanctions that should be imposed in any case where the I.G. has established liability.

Specifically, the CMPL and Section 1003.106 of the Regulations require me to examine: (1) the nature of the claims or requests for payment and the circumstances under which they were presented, (2) the degree of culpability of Respondent, (3) the history of prior offenses of Respondent, (4) the financial condition of Respondent, and (5) such matters as justice may require. Section 1003.106(b) of the Regulations contains some general guidelines for the interpretation and application of these aggravating and mitigating factors.

The I.G. must prove, by a preponderance of the evidence, any aggravating circumstances; Respondent must prove, by a preponderance of the evidence, any mitigating circumstances. 42 C.F.R. 1003.114(a), 1003.114(c). The Regulations provide that, in cases where mitigating factors preponderate, the penalty and assessment should be set appropriately below the maximum permitted by law, and where aggravating factors preponderate, the penalty and assessment should be set at or close to the maximum permitted by law. 42 C.F.R. 1003.106(c)(2). Therefore,

in determining the appropriate penalty, assessment, and period of exclusion, I must apply these factors to the 108 claims for which liability has been established.

While the CMPL and Regulations require consideration of aggravating and mitigating factors to determine the appropriate amount of the penalty, assessment, and the length of exclusion to be imposed in a given case, there is no formula set forth for computing them, and there is little guidance to be found in the CMPL and its legislative history (except with regard to assessments, see 48 Fed. Reg. 38827 (Aug. 26, 1983). Hume, supra, at pp. 21-29. The preamble to the Regulations state that "fixed numbers" have been "eliminated" as "triggering devices." This emphasizes that discretion is preferable to a mechanical formula. Id. The preamble further states: "as we gain more experience in imposing sanctions under the statute, we may further refine the guidelines, but at this early stage we believe that increased flexibility is preferable."

The ALJ must also keep in mind that the purpose of a civil monetary penalty in a CMPL case is deterrence and protection of the Medicare and Medicaid programs, rather than retribution or punishment. See, Mayers v. U.S. Department of Health and Human Services, 806 F.2d (11th Cir. 1986), cert. denied, 484 U.S. 822 (1987); Chapman v. United States of America, Department of Health and Human Services, 821 F.2d 523 (10th Cir., 1987). The dual purpose of deterrence is to encourage others to comply with the law and to discourage a respondent from committing the wrong again. Thus, to arrive at an appropriate penalty that would be a deterrent, rather than retribution, the ALJ must consider the factors outlined in the Regulations, weigh the gravity of the wrong done by a respondent, and attempt to prevent the wrong from being committed again by a given respondent and other providers.

The purpose of the assessment in a CMPL case is to enable the United States to recover the damages resulting from false or improper claims. The assessment includes amounts paid to a respondent by the Medicare and Medicaid programs and the costs of investigating and prosecuting unlawful conduct. See 48 Fed. Reg. 38831 (Aug. 26, 1983). See, H.R. Rep. No. 97-158, 97th Cong., 1st Sess. 329, 461-462 (1981), 1981 U.S. Code Cong. & Admin. News 727-28.

1. The I.G. Proved That the Nature and Circumstances of the Claims and Services at Issue Were aggravating Circumstances.

The guidelines at section 1003.106(b)(1) of the Regulations state that an aggravating circumstance exists where the requests for payment were of several types, occurred over a lengthy period of time, were large in number, indicated a pattern of making such requests for payment, or the amount was substantial. Again, the guidelines do not indicate what period constitutes a "lengthy" period, what number of requests is a "large" number, or what amount is a "substantial amount." See, 48 Fed. Reg. 38827 (Aug.26, 1983). These judgments are left to the discretion of the ALJ.

The guidelines, at section 1003.106(b) of the Regulations, state that it is a mitigating circumstance if the nature and circumstances of the requests for payment were all of the same type, occurred within a short period of time, were few in number, and the total amount requested from Medicaid recipients was under $1,000. The Regulations do not specify what constitutes a "short period of time" or how to evaluate the number of claims.

Since examples of aggravating circumstances in the guidelines are stated in the disjunctive, only one need be proven by the I.G. to establish the nature and circumstances of the claim at issue to be considered aggravating. Conversely, since examples of mitigating circumstances in the guideline are stated in the conjunctive, all must be proven by Respondent in order for the nature and circumstances of the claims at issue to be considered mitigating. Here, Respondent did not prove all of them.

Although the I.G. did not prove all of the aggravating circumstances which he alleged, he did establish more than one aggravating circumstance in this case. The I.G. proved that the claims for services at issue were provided over a lengthy period of time, were a substantial number, and involved a substantial amount claimed.

Respondent presented or caused to be presented 108 claims for services that were not provided as claimed, and Respondent submitted these claims with regularity from 1982 to 1985. The total amount claimed by Respondent on these claims was $1,960.71, which is a substantial

amount. Thus, the I.G. proved that the amounts claimed for the services at issue was substantial.

The I.G. also proved that there was a pattern to the claims submitted. Consistently, Respondent indicated that the service provided was an "office visit" although the medical record showed that the service was a prescription refill handled solely by telephone.

The I.G. did not prove that there were several types of services involved in this case. All of the services at issue were telephone prescription refills billed as "office visits."

2. The I.G. Proved That the Degree of Culpability of Respondent Was an Aggravating Circumstance.

One of the most complex of the factors to be considered by the ALJ in determining the amount of the penalty is the "degree of culpability." Hume, supra, at p. 24. The guidelines in the Regulations indicate that this factor relates to the degree of a respondent's knowledge and intent. Knowledge is an aggravating factor, and "unintentional or unrecognized error" is a mitigating factor if a respondent "took corrective steps promptly after the error was discovered." Regulations, section 1003.106(b)(2). Thus, the determination of the degree of culpability involves an inquiry into the degree of a respondent's knowledge. See, 48 Fed. Reg. 38831 (Aug. 26, 1983).

The I.G. proved that Respondent "knew" that, in 94 of the claims in issue, the services were not provided as claimed. She had reason to know and should have known that 108 of the claims in issue were not provided as claimed. It is an aggravating circumstance that Respondent had a reckless disregard for the Medicare and Medicaid program requirements, in that she knowingly ignored the requirements when presenting claims to Medicare and Medicaid. Respondent's testimony with respect to program requirements that "she thought every service should be reimbursable", coupled with her response that "it doesn't belong to my realm of interest" demonstrates a dangerously arrogant and reckless attitude for a provider of services to the Medicaid program. Tr. 891-92.

I conclude that Respondent did not prove that her presentment of claims was a result of unrecognized and

unintentional error or prove that corrective steps were taken promptly after the error was discovered.

3. The I.G. Did Not Prove a History of Prior Offenses as an Aggravating Circumstance.

The next factor discussed in the Regulations is "prior offenses." The guidelines in section 1003.106(b) state that an aggravating circumstance exists if, prior to the presentation of the improper claims at issue, a respondent had been held liable for criminal, civil, or administrative sanctions in connection with one of the programs covered by the CMPL or any other medical services program. This guideline would clearly prevent consideration of mere allegations of past wrongdoing. A respondent must have been held liable, subjected to actual sanctions, and the claims must not have been the subject of the instant proceeding. The preamble makes clear that prior offenses are not an aggravating circumstance, unless there has been a final agency determination or a final court adjudication. 48 Fed. Reg. 38832 (Aug. 26. 1983).

The I.G. did not prove that any sanctions had been imposed against Respondent.

4. Respondent Did Not Prove That Her Financial Condition Is a Mitigating Circumstance.

The regulations state that the financial condition of a respondent should constitute a mitigating circumstance if the penalty or assessment, without reduction, would jeopardize the ability of a respondent to continue as a health care provider. Thus, it is clear that the ALJ may consider a respondent's financial condition. Furthermore, the guidelines at section 1003.106 (b)(4) note that the ALJ must consider the resources available to a respondent. This indicates that financial disclosure by a respondent is a key requirement in evaluating a respondent's financial condition. Respondent has the burden of proving by a preponderance of the evidence that her financial condition would prevent her from being able to pay the penalty and assessment imposed in this case.

Respondent did not adduce any evidence pertaining to her current financial condition. Accordingly, there is no basis in the record upon which to limit the sanctions proposed, on grounds of financial condition.

5. Respondent Proved That Her Service To Her Patients Is A Mitigating Circumstance.

As I stated in Hume, supra, at p. 27, the CMPL and the Regulations also contain an umbrella factor: "other matters as justice may require." The Regulations do not provide further detail, except to indicate that consideration of other matters should be limited to those which relate to the purpose of civil money penalties and assessments. 42 C.F.R. 1003.106(b)(5).

The I.G. proved by a preponderance of the evidence that Respondent repeatedly violated the requirements of the Medicare and Medicaid programs and, as a result, received improper reimbursement. The I.G. asserts that the proposed penalty should be increased in this case because Respondent admitted that she had been billing for telephone prescription refills since the inception of her private practice. However, this action was brought on the basis of 111 claims, of which Respondent was given proper notice. There was no other evidence introduced in regard to other claims and such claims might well be barred by the statute of limitations in the CMPL. Accordingly, I have not considered any evidence other than that relating to this action and the 111 claims in issue.

The record establishes that Respondent has provided substantial services to indigent patients and they are well satisfied with her services. FFCL 112.

B. The Amount of the Penalty, Assessment, and Suspension, as Modified Here, is Supported by the Record.

The I.G. in his post-hearing brief requested that I increase the penalties proposed to the amount of $111,000.00, impose the assessments totalling $2,928.43, and impose an exclusion of five years.

After weighing all of the evidence in this case, inclusive of the existence of aggravating and mitigating circumstances, I conclude that the imposition of the penalties and assessments sought by the I.G. is slightly excessive. Also, I conclude that a five-year exclusion from participation in the Medicare and State health care programs is not reasonable.

I conclude that based on the record in this case, giving special weight to the contribution of Respondent to her community and based on my experience in other CMPL cases, a penalty of $49,000.00 is a sufficient deterrent under the circumstances of this case, and $2,797.81 is sufficient to compensate the Government.[10] I further conclude that an exclusion for a period of two years is sufficient to ensure the integrity of the Medicare and State health care programs.[11]

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[10] The total amount claimed by Respondent on the 111 claims in issue was $2,026.02. I found that Respondent is not liable on claims 19, 108, and 111, totalling $65.31. Thus, the total claimed for which she is liable is $1,960.71. I.G. Ex. 121. The maximum assessment is $3921.42 (2 x $1960.71). Allowing a credit of $1,123.61 for payment of restitution by Respondent, the maximum assessment is $2797.81.

[11] Following the hearing, I invited the parties to address the issue of whether the recent United States Supreme Court decision in United States v. Halper, 109 S. Ct. 1892 (1989), is applicable to the facts of this case. In Halper, the Supreme Court held that under some circumstances the imposition of a civil money penalty may violate the Double Jeopardy Clause of the Sixth Amendment to the United States Constitution. The Court held that the imposition of a penalty under the False Claims Act, 31 U.S.C. 3729-3231, could constitute prohibited double jeopardy in the narrow circumstance where there existed a prior federal criminal conviction for the false claims for which the civil penalty was imposed and where there was not even a remote relationship between the amount of the penalty and the cost to the government resulting from the false claims. This case is distinguishable from Halper, because Respondent was charged on State charges and not on federal charges, Respondent was prosecuted in State court and not federal court, and Respondent was not "convicted." Double jeopardy does not apply to a subsequent federal prosecution based on facts which led to a state conviction. Abbate v. United States, 359 U.S. 187 (1959); and Chapman v. U.S. Dept. of Health and Human Services, supra, 806 F.2d at 529. Therefore, Halper does not apply to this case and, in particular, has no limiting effect on the amount of the penalties, assessments, or exclusions I may impose.

ORDER

Based on the entire record, the CMPL, and the Regulations, it is hereby Ordered that:

(1) Respondent pay civil monetary penalties totalling $49,000.00;

(2) Respondent pay assessments totalling $2797.81;

(3) Respondent be excluded for a period of two years from the Medicare and Medicaid programs; and

(4) The corporate party, Corazon C. Hobbs, M.D., Inc., be dismissed as a party to this case.

/s/

Charles E. Stratton
Administrative Law Judge