Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Yung Hie Koh, M.D.,	)	Date: March 5, 1997
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-96-119
	)	Decision No. CR466
The Inspector General.	)	
	)	

DECISION

I sustain the determination of the Inspector General (I.G.) to exclude Petitioner, Yung Hie Koh, M.D., from participating in Medicare and State health care programs, including Medicaid programs, for a period of 10 years. In sustaining the exclusion, I find that the exclusion is authorized pursuant to section 1128(a)(1) of the Social Security Act (Act) and that it is reasonable.

I. Background

On November 30, 1995, the I.G. notified Petitioner that he was being excluded from participating in Medicare and State health care programs for a period of 10 years. The I.G. advised Petitioner that she was authorized to exclude Petitioner, because Petitioner had been convicted of a criminal offense related to the delivery of an item or service under the West Virginia Medicaid program (Medicaid). The I.G. further notified Petitioner that the term of the exclusion was based on the presence of three allegedly aggravating factors in Petitioner's case. These consisted of: the amount of financial damages caused to Medicaid by Petitioner's crimes and related conduct; the duration of Petitioner's unlawful conduct; and the fact that Petitioner was incarcerated as a consequence of his conviction.

The case was assigned to me for a hearing and a decision. I scheduled an in-person hearing. After reviewing the parties' proposed exhibits and Petitioner's list of witnesses, I suggested to the parties that the hearing might be conducted by telephone. The parties agreed to a hearing over the telephone. Therefore, on November 7, 1996, I conducted an in-person hearing by telephone. At that

hearing, I received into evidence I.G. Ex. 1 - 9 and P. Ex. 1.[1] I heard the testimony of Petitioner and of an additional witness, Ms. Diana Comer, who testified on Petitioner's behalf.

At the hearing, the I.G. alleged that there existed an aggravating factor in addition to those that she had identified in her November 30, 1995 notice to Petitioner. The I.G. alleged that Petitioner's criminal offenses, or similar acts, had an adverse pecuniary impact on one or more program beneficiaries or other individuals.

I afforded the parties the opportunity to submit posthearing briefs. Both the I.G. and Petitioner submitted a posthearing brief. I base my decision in this case on the governing law, the evidence that I received at the November 7, 1996 hearing, and on the parties' arguments.

II. Issues, findings of fact and conclusions of law

The issues in this case are whether Petitioner was convicted of a criminal offense within the meaning of section 1128(a)(1) of the Act and whether the 10-year exclusion that the I.G. imposed against Petitioner is reasonable. I make the following findings of fact and conclusions of law (Findings) to support my decision to sustain the exclusion that the I.G. imposed. I discuss each of these Findings in detail, below.

1. Under sections 1128(a)(1) and 1128(c)(3)(B) of the Act, the I.G. is mandated to exclude from participating in Medicare and Medicaid, for at least five years, any individual who is convicted of a criminal offense related to the delivery of an item or service under Medicare or a State health care program, including Medicaid programs.

2. The I.G. may exclude for more than five years an individual who has been convicted of an offense within the meaning of section 1128(a)(1) of the Act, if that individual is so untrustworthy as to necessitate an exclusion of more than five years.

3. Under regulations which govern the length of exclusions imposed pursuant to section 1128(a)(1) of the Act, an individual may be found to be so untrustworthy as to necessitate an exclusion of more than five years if there exist factors in that individual's case which are defined as aggravating, which are not offset by factors which are defined as mitigating.

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[1] P. Ex. 1 contains several attachments. However, Petitioner offered P. Ex. 1 as a single exhibit, and that is how I received it into evidence.

4. Petitioner is a physician who practiced pediatrics in West Virginia.

5. Petitioner pled guilty to, and was convicted of, perpetrating a scheme to defraud Medicaid by knowingly causing Medicaid to deliver a check to Petitioner generated as a result of Petitioner's submitting to Medicaid false claims for services that he did not provide.

6. The amount of Medicaid reimbursement to which Petitioner pled guilty to having obtained fraudulently is $13,259.01.

7. The total amount of Petitioner's fraud against Medicaid is in an amount which is substantially greater than the amount to which Petitioner pled guilty to having obtained by fraud.

8. The criminal scheme to which Petitioner pled guilty transpired over a period beginning in or about June 1991, and continuing through September 7, 1994.

9. As a consequence of his guilty plea and conviction, Petitioner was sentenced to serve a period of incarceration of from 10 to 16 months. Petitioner actually served a prison term of 13 months.

10. The I.G. proved that Petitioner was convicted of a criminal offense within the meaning of section 1128(a)(1) of the Act.

11. The I.G. proved the presence of an aggravating factor in that the acts resulting in Petitioner's conviction, or similar acts, resulted in financial loss to Medicaid of $1,500 or more.

12. The I.G. proved the presence of a second aggravating factor in that Petitioner engaged in crimes against Medicaid over a period of more than one year.

13. The I.G. proved the presence of a third aggravating factor in that Petitioner was sentenced to serve a period of incarceration as a result of his conviction of a criminal offense within the meaning of section 1128(a)(1) of the Act.

14. The I.G. did not prove the presence of an additional aggravating factor.

15. Petitioner did not prove the presence of any mitigating factor.

16. The evidence in this case establishes Petitioner to be a highly untrustworthy individual.

17. A 10-year exclusion is reasonable.

III. Discussion

A. Governing law (Findings 1 - 3)

The I.G. excluded Petitioner pursuant to section 1128(a)(1) of the Act. Section 1128(a)(1) mandates the I.G. to exclude any individual who is convicted of a criminal offense related to the delivery of an item or service under Medicare or under a State health care program, including a Medicaid program. Section 1128(c)(3)(B) of the Act requires that an exclusion imposed pursuant to section 1128(a)(1) be for a minimum of five years.

The Act implicitly authorizes the I.G. to exclude for more than five years an individual who is convicted of a criminal offense as defined by section 1128(a)(1) if the circumstances warrant an exclusion of more than five years.

Section 1128 of the Act, of which section 1128(a)(1) is a part, is a remedial statute. Its purpose is not to punish individuals, but to protect federally funded health care programs and their beneficiaries and recipients from individuals who are established to be untrustworthy. An exclusion imposed pursuant to section 1128 or any of its parts is reasonable if it relates reasonably to the legislative purpose of the Act. Congress concluded that an individual who is convicted of a program-related criminal offense within the meaning of section 1128(a)(1) has established by his or her criminal misconduct that he or she is so untrustworthy as to necessitate an exclusion of at least five years. But, Congress also recognized the possibility that such an individual may be so untrustworthy as to require an exclusion of more than five years.

The Secretary of the United States Department of Health and Human Services (the Secretary) has published regulations which establish the criteria for evaluating the trustworthiness of those individuals who are excluded under any of the parts of section 1128 of the Act, including section 1128(a)(1). These regulations are contained in 42 C.F.R. Part 1001. The regulation which specifically applies to exclusions imposed pursuant to section 1128(a)(1) is 42 C.F.R. § 1001.102.

This regulation establishes the exclusive criteria which may be used to evaluate the trustworthiness of an individual who is excluded pursuant to section 1128(a)(1). The regulation provides that, under section 1128(a)(1), an exclusion of more than five years may be reasonable if there exists evidence in an individual's case establishing the presence of any factors defined by the regulation to be aggravating which is not offset by evidence establishing the presence of any factors defined by the regulation to be mitigating. 42 C.F.R. § 1001.102(b)(1) - (6), (c)(1) - (3).

In effect, 42 C.F.R. § 1001.102 is the Secretary's conclusion of what evidence may be relevant to establishing trustworthiness.

I may not consider evidence which does not relate to one of the defined aggravating or mitigating factors in deciding whether an exclusion imposed pursuant to section 1128(a)(1) is reasonable.

However, evidence which establishes the presence of aggravating or mitigating factors is only the starting point in deciding of whether an exclusion imposed pursuant to section 1128(a)(1) is reasonable. The regulation authorizes an exclusion of more than five years where there exist aggravating factors that are not offset by mitigating factors. The regulation does not direct that an exclusion of more than five years, or of any particular length in excess of five years, be imposed in such a case. The determination of what is reasonable is left to the judgment of the administrative law judge in a hearing concerning an exclusion of more than five years imposed pursuant to section 1128(a)(1) of the Act.

In order to evaluate the reasonableness of an exclusion imposed pursuant to section 1128(a)(1), I must decide how any evidence that relates to an aggravating or mitigating factor establishes the trustworthiness of an excluded individual. Evidence that meets the test of one of the aggravating or mitigating factors may show that an individual is relatively trustworthy or relatively untrustworthy.

For example, an aggravating factor is established pursuant to 42 C.F.R. § 1001.102(b)(1) if the evidence proves that the acts resulting in an individual's conviction of a program-related offense, or similar acts, resulted in financial loss to Medicare or to a State health care program of $1500 or more. Assuming that evidence which proves the existence of this factor exists in a case, I would look at that evidence as a gauge of the excluded individual's trustworthiness to provide care. Proof that an individual caused a financial loss greatly in excess of $1500 would be evidence that the individual is a highly untrustworthy individual. By the same token, evidence that an individual caused a financial loss of $1500 or only slightly more than that amount, while establishing an aggravating factor, might not by itself prove the individual to be so untrustworthy as to require more than the minimum five-year exclusion.

B. The relevant evidence (Findings 4 - 9)

Petitioner is a physician, specializing in pediatric medicine, whose practice is located in Princeton, West Virginia. I.G. Ex. 1 at 1. On November 16, 1994, Petitioner was indicted on criminal charges in the United States District Court for the Southern District of West Virginia. Id. Petitioner was charged with devising a scheme to defraud Medicaid by making false claims for services that he did not provide. Id. at 1 - 2. The indictment described, in 15 separate counts, the acts by which Petitioner allegedly implemented his criminal scheme. Id. at 2 - 4. The separate counts each charge that, on specified dates, Petitioner implemented

his scheme by causing Medicaid to mail him reimbursement checks in specified amounts for fraudulent reimbursement claims made by Petitioner. Id.

On December 13, 1994, Petitioner agreed to plead guilty to count 13 of the indictment. I.G. Ex. 2 at 1. By agreeing to plead guilty to count 13, Petitioner specifically admitted to causing Medicaid to send him a reimbursement check in the amount of $13,259.01 for services that Petitioner claimed fraudulently that he had provided to Medicaid recipients, but which he did not provide. I.G. Ex. 1 at 3.

Count 13 describes a single episode of mail fraud. While it is true that Petitioner specifically pled guilty to only one count of the 15-count indictment against him, I find from the language of the indictment and Petitioner's plea agreement that, in pleading guilty, Petitioner acknowledged that he was guilty of both count 13 and of the overall criminal scheme to defraud Medicaid described in the indictment. The indictment lists count 13 as an act in furtherance of an underlying criminal scheme by Petitioner. I.G. Ex. 1 at 2. The essence of that scheme was to send false reimbursement claims to Medicaid of which the claim described in Count Thirteen is but one example. Id. And, although count 13 describes one check, dated July 12, 1994, the overall criminal scheme transpired over a period beginning in June 1991 and continued until September 7, 1994. Id. at 2 - 3.

The total dollar amount of fraudulent claims described in count 13 is $13,259.01. I.G. Ex. 1 at 3. There is no evidence in the record which establishes the precise dollar amount of Petitioner's total fraud, beyond that which he admitted to in pleading guilty to Count Thirteen. However, there is evidence which proves it to have been very substantial, and greatly in excess of the amount stated in count 13.

On January 12 1995, the United States Department of Justice (Justice Department) filed a civil action against Petitioner pursuant to the False Claims Act, 31 U.S.C. §§ 3729 - 3733, as amended. I.G. Ex. 7. The complaint was based on the same facts as were alleged in the indictment that had been filed against Petitioner. Id.; ___ I.G. Ex. 1. The complaint alleged that Petitioner had committed fraud against the United States in an amount exceeding $20,000.

On January 17, 1995, Petitioner entered into a consent judgment with the Justice Department in order to settle the civil action. I.G. Ex. 8. Petitioner and the Justice Department agreed to settle the case for a total of $500,000. Id. at 2.

I do not construe the consent judgment to be an admission by Petitioner of the precise amount of his fraud. Damages imposed under the False Claims Act are based on a formula which multiplies the number of false claims submitted by a culpable individual times a sum of not less than $5000 and not more than $10,000 and adds that amount to the actual damages sustained by the United States, plus the cost of litigation. See I.G. Ex. 7 at 4.

However, at the hearing of this case, Petitioner was asked by his attorney whether the $500,000 consent judgment constituted full restitution, or possibly, even more than full restitution, of the amount that Petitioner had obtained unlawfully. In response, Petitioner testified that he thought that the consent judgment was for an amount totaling about two to three times what was lost by Medicaid as a result of Petitioner's fraud. Tr. at 60 - 61. Petitioner qualified this testimony by stating that the amount he had obtained unlawfully included money to which Petitioner would have been entitled to receive from Medicaid for services provided by Petitioner, had Petitioner claimed the services lawfully. Id. Notwithstanding, Petitioner's testimony is an admission that he had defrauded Medicaid of much more than the $13,259.01 to which he pled guilty to having obtained by fraud.

This admission is corroborated by other evidence. On April 18, 1995, the United States District Judge (District Court judge) to whom Petitioner's criminal case was assigned notified Petitioner that he was considering an upward departure from the criminal fine that normally would be imposed against Petitioner under United States Sentencing Guidelines. I.G. Ex. 4. The District Court judge premised this notice on his conclusion that Petitioner had fraudulently obtained an estimated amount of $218,453.46. Id. at 1. The District Court judge stated that the fine guideline for Petitioner would normally be in a range from $3000 to $30,000. Id. He found that an upward departure in the fine would be appropriate where, as in this case, the unlawful gain by Petitioner or the loss to Medicaid exceeds two times the fine guideline. Id. The District Court judge subsequently imposed against Petitioner a fine of $150,000. I.G. Ex. 6 at 7.[2]

The sentence that was imposed on Petitioner included a period of incarceration of from 10 to 16 months. I.G. Ex. 5 at 5. The actual term of Petitioner's imprisonment was for 13 months. Id. at 2. In sentencing Petitioner, the District Court judge found that Petitioner was a "well-educated doctor who concocted an elaborate scheme to defraud the government . . . ." I.G. Ex. 6 at 3.

C. Evaluation of the evidence (Findings 10 - 13)

Petitioner has not disputed that he was convicted of a criminal offense within the meaning of section 1128(a)(1) of the Act. I conclude also that the I.G. proved that she has authority to exclude Petitioner pursuant to section 1128(a)(1). Petitioner's fraud against Medicaid plainly is related to the delivery of an item or

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[2] In the memorandum of the sentencing hearing, the District Court judge stated, without explanation, that the amount of Petitioner's unlawful gain was calculated as either $24,136.09 or $218,453.46. I.G. Ex. 6 at 7. For the reasons I discuss above, I conclude that Petitioner's fraud amounted to between $150,000 and $250,000. However, even if, in fact, it was in the amount of $24,136.09, I would nonetheless conclude that to be a very substantial fraud.

service under the Medicaid program. Petitioner could not have committed the fraud but for his false claims that he had provided items or services under Medicaid that, in fact, he had not provided.

An exclusion of at least five years is mandatory given the fact that Petitioner was convicted of a criminal offense related to the delivery of a Medicaid item or service. I find that the evidence in this case strongly supports the conclusion that Petitioner is a highly untrustworthy individual. In view of this high degree of untrustworthiness, a 10-year exclusion is reasonable.

The I.G. alleged the presence of four aggravating factors. She proved the existence of three of them. First, the I.G. proved that the amount of Petitioner's fraud against Medicaid exceeded $1500. 42 C.F.R. § 1001.102(b)(1). As I find above, Petitioner has admitted obtaining wrongfully an amount greatly in excess of $1500, totaling somewhere between $150,000 and $250,000.

Second, the I.G. proved that Petitioner perpetrated his fraud over a period of more than one year. 42 C.F.R. § 1001.102(b)(2). The scheme to which Petitioner pled guilty involved fraud committed over a period of more than three years.

Third, the I.G. proved that Petitioner was sentenced to incarceration for his fraud. 42 C.F.R. § 1001.102(b)(4). Petitioner was sentenced to a prison term of from 10 to 16 months and he was imprisoned for 13 months.

I do not find that the I.G. proved the presence of a fourth aggravating factor. At the hearing, the I.G. asserted that Petitioner's fraud had a significant financial impact on one or more program beneficiaries or other individuals. See 42 C.F.R. § 1001.102(b)(3). The I.G. premised this assertion on a statement by the District Court judge who sentenced Petitioner that Petitioner had caused significant pecuniary loss to taxpayers. I.G. Ex. 6 at 8.

I agree that Petitioner's fraud caused substantial loss to Medicaid, and by extension, to the taxpayers of West Virginia and the United States. However, I do not conclude that proof of theft from Medicaid, in and of itself, is sufficient to prove the existence of an aggravating factor under 42 C.F.R. § 1001.102(b)(3). If this aggravating factor were read to include any instance of fraud which causes financial damages to a federally funded health care program, as the I.G. alleges, then it would overlap, and for practical purposes, duplicate, the aggravating factor stated in 42 C.F.R. § 1001.102(b)(1). I do not find that the Secretary intended this consequence. The aggravating factor described in 42 C.F.R. § 1001.102(b)(3) makes sense as a separate aggravating factor only if it applies to circumstances where an individual's fraud against a federally funded health care program causes direct, measurable harm to an identifiable individual or individuals.

Evidence of such harm is not present here. I do not find the conclusion of the District Court judge that taxpayers had sustained a pecuniary loss as a result of Petitioner's fraud to support a finding that individual taxpayers sustained such a loss. The judge's conclusion, when read in the context of this case, is only that a taxpayer-supported program sustained a loss as a consequence of Petitioner's fraud.

I do not find that Petitioner presented credible evidence which establishes the presence of mitigating factors to rebut the proof of aggravating factors established by the I.G. Petitioner argues first, that under 42 C.F.R. § 1001.102(b)(1), any restitution that is paid to the government by an individual should offset any evidence of financial damages caused by that individual. Petitioner Brief at 3. Although the record of this case establishes that Petitioner has made substantial damage payments to the government, which indeed, may exceed the total dollar amount of his false claims, the fact that Petitioner has now paid restitution does not detract from the proof of the quantum of fraud committed by Petitioner. In publishing 42 C.F.R. § 1001.102(b)(1), the Secretary concluded that an individual's lack of trustworthiness may be measured by the size of that individual's fraud, and not by restitution that the individual may have made after the fact.

Second, Petitioner argues that, although he may have defrauded Medicaid, his fraud was the consequence of his misunderstanding of Medicaid reimbursement requirements, rather than a calculated effort to obtain monies unlawfully from the program. See Petitioner Brief at 2. In his testimony, Petitioner averred that he had erroneously failed to amend his Medicaid billing procedures in 1992, to address changes in the way Medicaid reimbursed physicians for their services. Tr. at 48 - 50. According to Petitioner, his subsequent indictment for and conviction of fraud resulted from this alleged error. Petitioner attempted to support this assertion with the testimony of Ms. Comer and a supporting affidavit executed by Ms. Comer. Tr. at 32 - 33; P. Ex. 1 at 29 - 32.

Petitioner's assertion that he may have erroneously made false claims rather than committing fraud would not, if credible, prove the presence of a mitigating factor. Arguably, if credible, the assertion might serve to explain and diminish the impact of some of the evidence which relates to aggravating factors. However, I do not find the assertion to be credible.

The credible evidence in this case is that Petitioner engaged in a pattern of false claims which he perpetrated over a period of more than three years. That fraud began in 1991 before Medicaid changed its reimbursement policies. Petitioner admitted as much when he pled guilty. The District Court judge who sentenced Petitioner found that Petitioner is a well-educated individual who concocted an perpetrated an elaborate fraud. I.G. Ex. 6 at 3.

Ms. Comer's testimony and her supporting affidavit do not support a conclusion that Petitioner merely made billing errors. She testified that she was employed by Petitioner. She asserted, essentially, that she and other members of Petitioner's office staff were confused by changes in Medicaid billing procedures, which had their inception in 1992. Tr. at 32 - 33; P. Ex. 1 at 29 - 32. This testimony is self-serving, and it begs the question of whether Petitioner, as opposed to members of his staff, knew and understood the consequences of the manner in which he submitted reimbursement claims to Medicaid. I note that Petitioner submitted Ms. Comer's affidavit to the District Court judge to support Petitioner's argument for a reduced sentence. See P. Ex. 1 at 29 - 32. The District Court judge made his finding that Petitioner had engaged in an elaborate fraud, despite this affidavit and other affidavits offered by Petitioner.

I do not find that Petitioner proved the existence of any mitigating factors set forth in 42 C.F.R. § 1001.102(c)(1) - (3). Petitioner argues that there is a dearth of primary pediatric providers in the area served by Petitioner and that his exclusion would therefore harm program beneficiaries and recipients who reside in that area. Petitioner's Brief at 3. The Secretary has not recognized a possible shortage of providers resulting from an exclusion imposed under section 1128(a)(1) of the Act to be a mitigating circumstance. See 42 C.F.R. § 1001.102(c)(1) - (3).[3]

At the hearing, Petitioner asserted that the discretionary part of his exclusion, consisting of the period of exclusion greater than five years, ought to be evaluated under regulations governing permissive exclusions, rather than that which applies to mandatory exclusions. In particular, Petitioner asserted that the length of his exclusion should be evaluated under 42 C.F.R. § 1001.201, which applies to convictions for fraud other than convictions for program-related fraud. Tr. at 43. Under 42 C.F.R. § 1001.201(b)(3)(iv), a mitigating factor would exist if an excluded individual proves that alternative sources of the care provided by that individual are not available elsewhere.

The provisions of 42 C.F.R. § 1001.201 plainly do not apply here. The regulation governing mandatory exclusions is intended to establish all of the criteria for evaluating such exclusions, including those criteria which are to be used for evaluating the length of exclusions imposed pursuant to section 1128(a)(1) of the Act which are for more than five years.

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[3] However, Congress and the Secretary have provided an avenue for a State to make such a determination and to request a waiver from that State's health care programs. Act, section 1128(d)(3)(B)(i); 42 C.F.R. § 1001.1801. There is no evidence in this case that Petitioner has asked any State to request a waiver on his behalf, or that a State has made a waiver request. Moreover, I have no authority to adjudicate the I.G.'s determination to grant or deny a waiver.

Petitioner argues also that his age ought to be taken into consideration in evaluating whether a lengthy exclusion is reasonable. Petitioner's Brief at 3. The Secretary has not concluded that the possibly advanced age of an excluded individual would constitute a mitigating factor. See 42 C.F.R. §1001.102(c)(1) - (3).

At the hearing, Petitioner asserted that he was punished harshly for his offenses, and that he is deterred by that punishment from committing fraud in the future. According to Petitioner, the punishment imposed against him coupled with a five-year exclusion provides ample protection against the possibility that Petitioner will in the future engage in conduct that is harmful to federally funded programs or to beneficiaries or recipients of those programs. Thus, according to Petitioner, an exclusion of more than five years is not necessary. Tr. at 24.

This argument reduces to an assertion that Petitioner has been deterred sufficiently by the punishment that was imposed against him, and that, consequently, a lengthy exclusion is not needed. However, the regulation does not permit me to consider the possible deterrent effect of punishment as a mitigating factor. See 42 C.F.R. § 1001.102(c)(1) - (3).

As I conclude at Part III.A. of this decision, the presence of aggravating factors not offset by mitigating factors does not establish necessarily that an exclusion of more than five years is reasonable in the case of an exclusion imposed pursuant to section 1128(a)(1). In any such case, I must evaluate the evidence that pertains to the aggravating factors to see what that evidence says about the excluded individual's trustworthiness to provide care.

Here, the evidence shows Petitioner to be a highly untrustworthy individual. In reviewing the evidence, I am struck not only by the amount of Petitioner's fraud but by the persistence with which he committed it. There is ample evidence in this case that Petitioner engaged in a pattern of calculated fraud over a period of several years which caused substantial financial loss to Medicaid. The persistence with which Petitioner committed his fraud, coupled with the size of the fraud, establishes that Petitioner is an individual who is capable of ignoring the requirements of law to suit his self-interest. Perhaps, more important, it shows that Petitioner was willing to do so consistently, and that he ceased his unlawful conduct only when he was caught engaging in it. Given this evidence of Petitioner's propensity to commit fraud, a 10-year exclusion is a reasonable protection for federally funded health care programs and for the beneficiaries and recipients of these programs.

IV. Conclusion

I conclude that the I.G. is authorized, pursuant to section 1128(a)(1) of the Act, to exclude Petitioner. I conclude further that the 10-year exclusion imposed by the I.G. is reasonable.

/s/

Steven T. Kessel
Administrative Law Judge