DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Appeals Board

Civil Remedies Division

In the Case of: The Inspector General, - v. - Dean G. Hume, D.O., Respondent.	DATE: AUG 22, 1989 Docket No. C-50 DECISION CR 40

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) informing Dean G. Hume, D.O. (Respondent) that the I.G. was seeking a civil monetary penalty of $135,000, an assessment of $4,948.20, and a ten year exclusion of Respondent from participation as a medical provider in the Medicare, Medicaid, and other federal and state health care programs. In the Notice, 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 Medicare and Medicaid payment. The I.G. alleged that Respondent had claimed to have provided 270 medical items or services, during the period from December 1983 to January 1986, and that Respondent knew, had reason to know, or should have known that the items or services were not provided as claimed.

Respondent filed a timely appeal to the Notice (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, 42 U.S.C. 1320a-7a (42 U.S.C.A. 1320a-7a, West Supp. 1989). See Stip. A2.

II. The Regulations

The governing federal regulations (Regulations) are codified in 42 C.F.R. sections 1003.100 through 1003.133 (1988). These Regulations provide for a full and fair trial-type hearing before an ALJ, implement the provisions of the CMPL, delegate authority from the Secretary to the I.G. and his delegates to make determinations regarding the CMPL, and provide for appeals from an ALJ's decision and order.

BACKGROUND [1]

Dr. Dean G. Hume, a doctor of osteopathic medicine, was engaged in the general practice of medicine in Des Moines, Iowa for about fifty years, until he surrendered his license in March 1986. Tr. 382. Dr. Hume enrolled as a provider with the Iowa Medicaid program on or about September 1, 1977. Supp. Stip. 6. He was also enrolled as a provider with Blue Cross/Blue Shield of Iowa, the

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

Feb 29, 1989 Stipulation of Facts	Stip. (number)
March 8, 1989 Supplemental of Facts	Supp. Stip. (number)
Hearing Transcript	Tr. (page)
I.G.'s Exhibits	I.G. Ex. (number)/ (page)
Respondent's Exhibits	R Ex. (number)/(page)
Respondent's Brief	R Br. (page)
Respondent's Reply Brief	R Rep. Br. (page)
I.G.'s Brief	I.G. Br. (page)
I.G.'s Reply Brief	I.G. Rep. Br. (page)
ALJ Findings of Fact and Conclusions of Law	FFCL (number)
March 1, 1989 ALJ Ruling	ALJ Ruling

Medicare carrier, at all times pertinent to this action. Supp. Stip. 6, 7.

The Notice was issued on July 22, 1988 by Eileen T. Boyd, Deputy Assistant I.G., and listed items or services in the Appendix to the Notice as line items one through 270. Stip. B2, B3, B5, B6. The I.G. charged that Dr. Hume had vacationed in Florida during the winter months of 1983 through 1986 and, during these periods, had allowed his untrained bookkeeper and other office personnel to treat patients in his absence. Tr. 9. The I.G. charged that these untrained persons were allowed to dispense medication, provide injections, perform urinalysis, refill prescriptions, and present pre-signed insurance forms to the Medicare and Medicaid programs for reimbursement, while the Respondent was in Florida. The I.G. further contended, as an aggravating circumstance, that Dr. Hume had failed to provide adequate documentation for 1309 additional claims. Respondent requested $1994.60 from the Medicaid program for 218 line items, and $480.00 from the Medicare program for 52 line items; Respondent was paid $2,052.67 by the Medicaid and Medicare programs. Stip. B2. Finally, the I.G. alleged that, because Dr. Hume had been previously found guilty in State Court of the charge of submitting fraudulent claims, Dr. Hume was collaterally estopped from providing a defense for 246 out of the 270 line items in issue. I.G. Br. 41; Tr. 10-11; R Br. 2.

In his September 19, 1988 Request, Respondent refuted the I.G.'s allegations and asserted that he either (1) had provided the services or (2) had properly supervised other medical providers in their provision of the items or services as claimed. RBr, 7-14. Respondent argues that, if I find that liability was proven by the I.G., the mitigating circumstances should reduce the amount of any penalty and assessment to the amount of actual damages to the Medicare and Medicaid programs. R Br. 15-22; R Rep. Br. 4.

I conducted a prehearing conference on November 15, 1988, and a formal evidentiary trial-type hearing on March 14 and 15, 1989, in Des Moines, Iowa.

At the hearing, the I.G. presented five witnesses, Respondent testified on his own behalf, and both parties entered exhibits into the record. Each of the parties

filed two post-hearing briefs and proposed findings of fact and conclusions of law.[2] [3]

PREHEARING RULINGS

On January 5, 1989, the I.G. moved to bar Respondent from relitigating 246 of the 270 items or services at issue in this case, alleging that they were the subject matter of a prior "final determination" within the meaning of section 1003.114(c) of the Regulations. Respondent admits that he was found guilty and that items one through 246 were the subject matter of his criminal conviction. Stip. B5. On March 1, 1989, I issued a Ruling in which I found and concluded that (1) Respondent was barred from relitigating line items one through 246 because they were the subject matter of a "final determination" in Respondent's State Court criminal case, and (2) that liability for the claims containing line items one through 246 was established by section 1003.114(c) of the Regulations. This left line items 247-270 remaining in issue at the hearing. See Tr. 12.

ISSUES

The issues are:

I. Liability.

1. Whether the I.G. proved, by a preponderance of the evidence, that Respondent knew, had reason to know, or should have known that the Medicare and Medicaid items or services at issue, and listed as items 247-270, were not provided as claimed, in violation of the CMPL and Regulations.

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

[3] After the hearing, I invited the parties to address (in their reply briefs) the issue of whether the recent United States Supreme Court decision in United States - v.- Halper, ______ U.S.______ (1989), 57 U.S.L.W. 4526 (1989), is applicable to this case.

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

1. Whether the I.G. proved by a preponderance of the evidence the aggravating circumstances alleged.

2. Whether the Respondent proved by a preponderance of the evidence any circumstances that would justify reducing the amount of the penalty, the assessment, or the period of exclusion proposed by the I.G.

3. Whether the recent United States Supreme Court decision in United States - v.- Halper, ____ U.S.____, 57 U.S.L.W. 4526 (1989), is applicable to this case.

FINDINGS OF FACT AND CONCLUSIONS OF LAW [4]

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:

1. For the purposes of this proceeding, I have taken judicial notice of the statutes of the United States, the regulations of the Secretary of the Department of Health and Human Services (Secretary), the statutes of the State of Iowa, and the regulations of the Iowa Department of Human Services (formerly the Iowa Department of Social Services). Supp. Stip. 1.

2. Respondent, Dean G. Hume, D.O., was engaged as a physician in the general practice of medicine for approximately fifty years. He surrendered his license to practice medicine in March 1986. I.G. Ex. 4/5, 5; Tr. 89-90, 381, 482-483.

3. Respondent graduated from the University of Osteopathic Medicine in 1938. He was a member of the American Osteopathic Association from the time he was licensed until approximately 1983-1984, when he elected to relinquish his membership. Tr. 381, 439.

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[4] 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.

4. At all times pertinent to this action, the Iowa Department of Human Services (IDHS), formerly known as the Iowa Department of Social Services, was the agency designated to administer the Medicaid program in Iowa. Supp. Stip. 5.

5. Respondent enrolled as a provider with the Iowa Medicaid Program on or about September 1, 1977, and remained enrolled at all times pertinent to this action. Supp. Stip. 6.

6. Instructions governing participation in the Iowa Medicaid program are set forth in the Iowa Medicaid Provider Manual. Supp. Stip. 3.

7. Regulations governing the provision of services and submission of claims for reimbursement under the Iowa Medicaid program are set forth in the Iowa Administrative Code (IAC). Supp. Stip. 4; Tr. 272, 282.

8. It is the policy of the IDHS to send a copy of the Iowa Medicaid Program Provider Manual and copies of subsequent amendments to all participating physicians. I.G. Ex. 12-5/1.

9. Respondent received a copy of the Iowa Medicaid Program Provider manual and copies of subsequent amendments. I.G. Ex. 12-5; Tr. 493-494.

10. At all times pertinent to this action, the Respondent was enrolled with Blue Cross/Blue Shield of Iowa (BCBS), the designated Medicare carrier in Iowa. Supp. Stip. 7.

11. Regulations and instructions governing participation in the Medicare program are set forth in the Medicare Medical Assistant Manual and Medicare Bulletins. Supp. Stip. 4; Tr. 272, 282.

12. BCBS sends copies of the Medicare Medical Assistant Manual and Medicare Bulletins to all participating physicians. Tr. 272.

13. The Medicare Medical Assistant Manual and Medicare Bulletins were sent to Respondent. Tr. 272.

14. Respondent received a copy of the Medicare Medical Assistant Manual and Medicare Bulletins. Tr. 493-494.

15. As a provider of services, the Respondent was obligated to make himself aware of program requirements.

16. Respondent presented or caused to be presented to the Medicare program, claims for reimbursement containing 52 line items for services allegedly performed between December 1983 - January 1986. Stip. B2.

17. Respondent was reimbursed $480.00 for the 52 line items, which were on claims presented to the Medicare program. Stip. B3.

18. Respondent presented or caused to be presented to the Medicaid program claims containing 218 line items for items and services allegedly rendered during the period December 1983 - January 1986. Stip. B2.

19. Respondent was reimbursed $1,994.60 for the 218 line items, which were on claims presented to the Medicaid program. Stip. B3.

20. On November 21, 1986, Respondent was charged in Iowa District Court with violating section 714.8 and 714.11 of the Code of Iowa, Fraudulent Practice in the Third Degree, by "knowingly executing or tendering, under penalty of perjury, a false affidavit or certification given in support of a claim for compensation, thereby illegally receiving payments under Medicaid in an amount in excess of one hundred dollars. . . ." I.G. Ex. 15.

21. On November 21, 1986, Respondent was found guilty of the charge of Fraudulent Practice in the Third Degree. I.G. Ex. 15; Stip. B5, 11.

22. On November 21, 1986, Respondent executed a Statement Confessing Judgment by which he declared that he had received overpayments totalling $1,1917.39 as a result of claims submitted to the Medicare and Medicaid programs on behalf of his medical practice. Stip. B4, 11.

23. Respondent's judgment was deferred and he was placed on probation for two years and ordered to pay $1,809.97 of restitution to the Medicaid program and $107.42 of restitution to the Medicare program. Stip. B5, 11.

24. The claims presented by Respondent, containing line items one through 246, were the subject matter of a "final determination" in Respondent's criminal State court proceeding within the meaning of section 1003.114(c) of the Regulations.

25. I issued a Ruling which addressed the effect of the determinations made in Respondent's prior criminal State court proceeding. ALJ Ruling. I ruled that Respondent

was barred from relitigating the issue of liability for the claims containing line items one through 246, and I affirm that March 1, 1989 Ruling. Respondent's liability with respect to those claims was established prior to this hearing. ALJ Ruling.

26. At the hearing, the remaining issues regarding liability involved the claims containing line items 247-270.

27. All claims at issue were presented, or caused to be presented, on "HCFA 1500" forms. Supp. Stip. 10.

28. HCFA 1500 forms contain a block for the physician's signature. I.G. Ex. 29.

29. Respondent signed the claims, which he presented or caused to be presented to the Medicaid and Medicare programs. Supp. Stip. 10; Tr. 485-486.

30. By signing block 25 of the HCFA 1500 forms, subsequently presented to the Medicare program for reimbursement, Respondent certified that the services listed on the form were medically indicated and necessary for the health of the patient and were personally rendered by him or were rendered incident to his professional service by an employee under his immediate personal supervision. I.G. Ex. 29; FFCL 29; Tr. 277, 486.

31. By signing block 25 of HCFA 1500 forms, presented to the Medicaid program for reimbursement, Respondent certified that the services were personally rendered by him or by his employee while under his personal direction. I.G. Ex. 29; FFCL 29; Tr. 277, 486.

32. A Medicare Bulletin, dated August 7, 1979, was sent to all participating physicians in Iowa. The Bulletin provided that services rendered by physicians' assistants had to be provided under the physician's direct personal supervision. I.G. Ex. 28/2; Tr. 272, 282.

33. A Medicare Bulletin, dated May 1, 1981, was sent to all participating physicians in Iowa. The information reiterated Medicare's requirements for services provided to beneficiaries by the physician's auxiliary staff. Specifically, services provided by the physician's auxiliary staff would only be covered by Medicare if the auxiliary staff was directly supervised by the physician. "Direct personal supervision" requires the physician's presence while services are being provided to a

beneficiary by the physician's auxiliary staff. I.G. Ex. 28/3; Tr. 272, 282.

34. The May 1982 revision to the Medicare Medical Assistant Manual included the above definition for "direct personal supervision." I.G. Ex. 26-1/1-2; Tr. 273-277.

35. The November 1982 revision to the Medicare Medical Assistant Manual provided that, in the office setting, the physician's presence in the same room with the auxiliary staff performing the services was not required. I.G. Ex. 26-1/2.

36. The July 1985 revision to the Medicare Medical Assistant Manual provided that direct personal supervision required the physician's presence in the same office suite, not necessarily the same room where an auxiliary staff member was providing services. However, the physician was required to be available to provide immediate assistance and direction. I.G. Ex. 27

37. Respondent received the Medicare Bulletin dated May 1, 1981. Tr. 493-494.

38. Effective February 13, 1985, the Iowa Administrative Code provided that payment will be made to physicians for services rendered by auxiliary personnel employed by, and working under, the direct supervision of the physician. I.G. Ex. 12-5/2, 12-4.

39. The April 1, 1985 revision to the Iowa Medicaid Program Provider Manual, issued by the Iowa Department of Social Services, defined auxiliary personnel as nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists, and physical therapists. Requirements for the provision of services by auxiliary personnel are consistent with that of the Iowa Medicare program. I.G. Ex. 12-5/10-11.

40. During her employment, Ms. Bradberry provided assistance to Respondent in his medical practice. I.G. Ex. 1, 17.

41. Ms. Bradberry was one of Respondent's auxiliary personnel.

42. Prior to going on vacation, Respondent instructed Ms. Bradberry to dispense and refill prescriptions, provide injections, perform urinalyses, and assist patients onto the osteopathic table. I.G. Ex. 1; Tr. 326-329, 396, 433.

43. Respondent vacationed in Florida during the month of January 1986. I.G. Ex. 1, 16; Tr. 321-323, 446.

44. During that period, Ms. Bradberry dispensed and refilled prescriptions, gave injections, performed urinalyses, and assisted patients onto the osteopathic table. I.G. Ex. 1, 17.

45. Respondent signed blank claim forms for Ms. Bradberry's use while he was on vacation during the month of January 1986. I.G. Ex. 1, 17; Tr. 486.

46. Respondent instructed Ms. Bradberry to use the presigned claim forms to request reimbursement from the Medicare and Medicaid programs for services which she provided to patients in the Respondent's absence. I.G. Ex. 1, 17.

47. Ms. Bradberry used the presigned claim forms to request reimbursement from the Medicare and Medicaid programs for services which she performed for Respondent's patients during his absence in January 1986. I.G. Ex. 1, 17.

48. Claims for line items 247 - 270 were for services provided during the month of January 1986. Supp. Stip. B2.

49. Respondent did not personally render any of the items or services provided during the month of January 1986, as listed in claims containing line items 247 -270. Tr. 395, 446.

50. A Medicare Bulletin, dated May 4, 1979, was sent to all physicians in Iowa clarifying the fact that "services" provided by a telephone call between a physician and a patient, or visits for the sole purpose of obtaining or renewing a prescription, where no examination was needed, would not be reimbursable. I.G. Ex. 28/1; Tr. 272, 282.

51. Respondent received the Medicare Bulletin dated May 4, 1979. Tr. 493-494.

52. Respondent was not aware of the requirements as set forth in the May 4, 1979 Medicare Bulletin. Tr. 185, 494.

53. Respondent telephoned Ms. Bradberry during the month of January 1986, with instructions as to items or services which were to be provided to patients. Tr. 396.

54. Respondent did not directly supervise Ms. Bradberry while she performed the services claimed in line items 247-270. I.G. Ex. 28/3; FFCL 53; Tr. 397.

55. The I.G. proved, by a preponderance of the evidence, that Respondent had reason to know and should have known that the Medicare and Medicaid items or services at issue, and listed as items 247 through 270, were not provided as claimed. FFCL 9, 15-16, 30-34, 37-40, 52.

56. The amount of penalty and assessment, and the length of exclusion from participation in the various programs, is to be determined by reviewing: (1) the nature and circumstances under which the requests for payment were made; (2) the degree of Respondent's culpability; (3) the existence of prior offenses; (4) Respondent's financial condition; and (5) any other matters that justice may require. 42 C.F.R. 1003.106, 1003.107.

57. The I.G. proved that it is an aggravating circumstance that the claims presented by Respondent contained at least five different types of items and services. Supp. Stip. 8.

58. The I.G. proved that it is an aggravating circumstance that the services or items were provided over a lengthy period of time. Stip. B2.

59. The I.G. proved that it is an aggravating circumstance that there were a substantial number of claims involved in this case. Stip. B2.

60. Respondent vacationed in Florida during the winter months of 1983-1986. Tr. 426-431; I.G. Ex. 1, 17.

61. The I.G. proved that it is an aggravating circumstance that there was a pattern of claims for the services or items presented or caused to be presented by Respondent. Stip. B2.

62. The I.G. proved that it is an aggravating circumstance that the amount claimed for the 270 services or items was substantial. Stip. B3.

63. Respondent did not prove, by a preponderance of the evidence, that the services were of the same type. Supp. Stip. 8

64. Respondent did not prove, by a preponderance of the evidence, that the services and items were provided within a short period of time. Stip. B2.

65. Respondent did not prove, by a preponderance of the evidence, that there were few services or items involved in this case. Stip. B2.

66. Respondent did not prove, by a preponderance of the evidence, that the total amount claimed for the 270 services or items was less than $1,000. Stip. B3.

67. Respondent was convicted of "knowingly executing or tendering, under penalty of perjury, a false affidavit or certificate given in support of a claim for compensation, thereby illegally receiving payments under Medicaid in an amount in excess of $100. Stip. B3.

68. The I.G. proved that it is an aggravating circumstance that Respondent knew that the claims containing line items one through 246 were not provided as claimed. FFCL 21.

69. The I.G. did not prove, by a preponderance of the evidence, that Respondent knew that the claims containing line items 247 through 270 were not provided as claimed. FFCL 52.

70. Respondent did not prove, by a preponderance of the evidence, that the claims containing line items one through 246 were the result of an unintentional and unrecognized error in the process by which Respondent presented claims. FFCL 32.

71. Respondent did not prove, by a preponderance of the evidence, that it is an mitigating circumstance that the claims containing line items one through 270 were the result of an unintentional and unrecognized error and that he took corrective steps promptly.

72. The I.G. did not prove, by a preponderance of the evidence, 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.

73. Respondent did not prove, by a preponderance of the evidence, that the imposition of the proposed penalty and assessment, without reduction, would jeopardize Respondent's ability to continue as a health care provider. Rep. Br. 6.

74. Respondent does not have the necessary resources to pay the maximum penalty and assessment which the I.G. seeks to impose. Rep. Br. 6; Tr. 482-483.

75. On March 5, 1965, Respondent pled guilty to two counts of illegally dispensing controlled substances without a prescription, in violation of federal law. I.G. Ex. 7. The I.G. proved that it is an aggravating factor that the Respondent admitted that no medical justification existed for his actions. I.G. Ex. 7/10.

76. The I.G. proved that Respondent's 1965 conviction is an aggravating circumstance.

77. The Iowa Board of Medical Examiners disciplined the Respondent based upon his conviction in 1965. On June 24, 1965, the Board suspended the Respondent's license to practice medicine for a six month period and subsequently placed him on probation. I.G. Ex. 4/5, 8.

78. The I.G. proved that Respondent's administrative sanctions, as a result of his 1965 conviction, are an aggravating circumstance.

79. The I.G. did not prove, by a preponderance of the evidence, that Respondent's delegation of certain duties to be performed by his assistants, in his absence, is an aggravating circumstance.

80. The I.G. did not prove, by a preponderance of the evidence, that Respondent repeatedly violated the requirements of the Medicare and Medicaid programs through the presentment of 1309 undocumented claims, in addition to the 270 items and services at issue in this case. Tr. 392-393, 397.

81. Respondent proved by a preponderance of the evidence that it is a mitigating circumstance that he suffers from a serious medical illness. REx. 14, 16; Tr. 401-402.

82. The I.G. did not prove, by a preponderance of the evidence, all of the aggravating circumstances which he alleged. FFCL 69, 72, 80.

83. The Respondent proved by a preponderance of the evidence that circumstances exist which would justify reducing the amount of penalty and assessment, or the period of the exclusion imposed.

84. The recent United States Supreme Court decision in <u>United States v. Halper</u>, _______ U.S. ________ 57 U.S.L.W 4526 (1989), is not applicable to this case.

85. The appropriate amount of civil monetary penalty in this case is $73,500, the appropriate assessment is 4,948.20, and the appropriate period of exclusion is ten years.

DISCUSSION

I. The Elements Of Liability Under The CMPL And Regulations.

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. These sanctions are in addition to any other penalties that may be prescribed by law.

To establish liability, the CMPL and Regulations require the I.G. to prove all of the elements of liability. The elements that the I.G. must prove are: (1) that a respondent (2) who "presented or caused to be presented" (3) a "claim" at issue (4) to the Medicare or Medicaid programs (5) for "a medical or other item or service" (6) knew, had reason to know, or should have known that (7) the items or services in issue were "not provided as claimed." CMPL 1320a-7a(1)(A)(B)(C); Regulations 1003.102(a)(1).[5]

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.

[5] "Claim" is defined as an application for payment submitted for an item or service for which payment may be made under the Title XVIII (Medicare) Title XIX (Medicaid) or Title V (Maternal and Child Health Services Block Grant) programs. 42 U.S.C. Section 1320a(i)(2); 42 C.F.R. Section 1003.101.

II. The I.G. Proved Liability By A Preponderance Of The Evidence.

A. Line Items One Through 246.

I find and conclude that, based on the principles of collateral estoppel set forth in section 1003.114 (c) of the Regulations, the I.G. proved, by a preponderance of the evidence, that the items and services in issue (and identified as line items one through 246 in the Appendix to the I.G.'s Notice) were presented by Respondent and that he knew that these items or services in issue were not provided as claimed. This finding and conclusion is based on the fact that Respondent's criminal conviction, is a prior "final determination" within the meaning of section 1003.114(c) of the Regulations. Stip. B4., B5. Supp. Stip. 11. As stated earlier, prior to the hearing I issued a Ruling in which I held that Respondent's prior "final determination" established liability (for items one through 246). This left line items 246-270 at issue at the time of the hearing.

B. Line Items 247-270.

Based on the entire record in this case, I find and conclude that the I.G. proved by a preponderance of the evidence that Respondent violated the CMPL and Regulations because he had reason to know and should have known that the Medicare and Medicaid items or services at issue, and listed as items 247-270, were not provided as claimed.

1. Most of the Elements of Liability Were Conceded.

Most of the elements of liability have been conceded by Respondent. First, Respondent admits that all the items or services at issue were listed on HCFA 1500 claim forms and were presented or caused to be presented by him. Supp. Stip. 10. The parties stipulated that the five types of items or services at issue were described by using the following procedure codes:

97260	Manipulation, (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist (separate procedure), performed by physician, one area.
90050	Office medical service, established patient; limited service.
81000	Urinalysis, routine (PH specific gravity, protein, test for reducing

	substances such as glucose), with microscopy.
N1020	Alpha Redisol, 1000 mg/cc.
N1160	Estrogen injection, up to 2 mg. per cc.

The parties also stipulated to the authenticity and admission into evidence of documentation, pertaining to Respondent, contained in the files of the Iowa Board of Medical Examiners, the Iowa Department of Inspections and Appeals, the Medicaid Fraud Control Bureau, and Blue Cross/Blue Shield of Iowa. Supp. Stip. 12, 13,14.

Thus, all of the elements of liability have been stipulated to, except whether the items or services in issue (listed as 247-270) were personally provided by Respondent or were provided under his personal direction or personal supervision. The I.G. had the burden of proving by a preponderance of the evidence that items 247-270 were "not provided as claimed" and that Respondent "knew or should have known" that they were not provided as claimed.

2. The Medicaid Services listed by Respondent were "Not Provided as Claimed."

There is no doubt that items 247-270 were "not provided as claimed." The I.G. proved that Respondent did not personally provide these items or services and that he did not personally direct or supervise his employee's provision of these items or services as required.

Respondent testified during the hearing that he was on vacation in Florida during the month of January 1986. The claims containing line items 247-270 were for items or services which were listed as having been provided during that month. Respondent's testimony that he was on vacation in Florida during the month of January 1986 was corroborated through the affidavit of Al Pamquist, owner of the Bay Breeze motel in Clearwater, Florida, as well as through the deposition of Sharon Bradberry, Respondent's assistant.

Mr. Pamquist stated that he personally observed Respondent "nearly on a daily basis," at the Bay Breeze Motel in Clearwater, Florida during the month of January 1986. Ms. Bradberry declared that Respondent was on vacation during the month of January 1986. Thus, Respondent could not have personally rendered any of the items or services listed in line items 247-270.

The I.G. has also proved that Respondent's employee did not provide the items of services while under Respondent's personal direction or supervision, as claimed.

Respondent defended the submission of claims for services provided in his absence by asserting that the definition for the phrase "direct personal supervision" was not written on the HCFA 1500 form that Respondent presented for payment. Respondent is correct in his assertion. However, the term "direct personal supervision" is defined in Medicare and Medicaid publications. In the Medicare Medical Assistant Manual bulletins dated August 1979, May 1981, May 1982, and July 1985, the terms "direct personal supervision" were defined to require the physician's presence during the provision of services by the physician's auxiliary personnel. FFCL 34-37. The April 1985 and July 1986, Iowa Department of Human Services bulletins defined "direct personal supervision" to require the physician's presence in the same office suite, not necessarily the same room, where the Medical Provider's assistant is providing the items or services. Also, the physician would need to be available to provide immediate assistance or direction. FFCL 40.

Respondent's assistant, Sharon Bradberry, declared that Respondent instructed her to provide items or services while he was on vacation in Florida, and that she provided various items or services in his absence. Thus, the provision of items or services by Respondent's assistant did not comply with the requirements set forth above.

In further defense of Respondent's submission of claims reflecting items or services provided during the month of January 1986, Respondent testified that he had provided instruction and supervision to his assistant through telephone calls which he made to her on every Tuesday and Thursday throughout his absence. However, the issue of whether Respondent telephoned his assistant, as he testified, is irrelevant because the definition of personal direction or supervision requires the physician's physical presence during the provision of the items or services. FFCL 50.

3. The I.G. proved that Respondent Had Sufficient Knowledge for Liability to Attach.

a. The Element of knowledge Required by the CMPL and Regulations.

The final element of liability that the I.G. must prove for liability to be established in a CMPL case is knowledge.

As I stated in my Decision and Order in The Inspector General v. George A. Kern, M.D., Docket No. C-25, decided August 26, 1987, at pp. 5-8, all the elements of liability set forth in the CMPL and Regulations are straightforward and need little interpretation, with the exception of the element of knowledge -- the most difficult element to apply. The element of knowledge required for liability to attach is that a person "knows" or "should know" that any item or service claimed was not provided as claimed.[6]

In analyzing the breadth and scope of the element of knowledge required for liability to attach under the CMPL, I am guided by the preamble to the Regulations, which declares: "The statute sweeps within its ambit not only the knowing, but the negligent. . . ." 48 Fed. Reg. 38827, 38831 (Aug. 26, 1983). From this, and from analyzing the CMPL and Regulations, I conclude that the phrase "knows or should know" in the CMPL and the phrase "knew or had reason to know" in the Regulations encompass a spectrum of knowledge where liability attaches on one end when a respondent files false claims with actual knowledge and on the other end where a respondent files false or improper claims in a negligent manner.

b. The I.G. Did Not Prove By A Preponderance Of The Evidence That Respondent Had Actual Knowledge.

The I.G. did not prove by a preponderance of the evidence that Respondent knew that items 247-270 were not provided as claimed at the time the claims were presented.

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[6] The CMPL and Regulations contain slightly different language with regard to the element of knowledge. Under section 1320a-7a(1)(a) of the CMPL, liability attaches when the person "knows or should know." Under section 1003.102(a)(1) of the Regulations, liability attaches when the person "knew or had reason to know."

Respondent's position was that the items or services (247-270) were rendered under his personal direction or supervision and, thus, were provided as claimed. He based this position upon the fact that the terms "personal direction or supervision," were not defined on the HCFA 1500 forms which he presented. I previously determined that Respondent was sent, and received, publications from the Medicare and Medicaid programs which contained a definition of the terms "personal direction or supervision." However, I did not determine that Respondent was aware of the contents of the publications because the I.G. did not prove this factor by a preponderance of the evidence. Respondent testified that he received publications from the Medicare and Medicaid programs and that the publications were kept in his office. He also testified that he could not recall whether he had ever read any of the publications which he received, but that it was his assistant's responsibility to read the bulletins and to make sure that Respondent acted in compliance with the law.

The I.G. is correct in his assertion that Respondent, because of his vacation in Florida during the month of January 1986, had actual knowledge that he did not personally provide the items or services at issue. However, the I.G. did not prove, by a preponderance of the evidence, that Respondent was actually aware of the requirements of "personal supervision or direction." Therefore, the I.G. did not prove, by a preponderance of the evidence, that Respondent had actual knowledge that the items or services were not provided as claimed.

c. The I.G. Proved that Respondent "Had Reason To Know."

The I.G. proved liability by establishing that Respondent "had reason to know" that the items and services at issue were not provided as claimed.

As I stated in my Decision and Order in The Inspector General v. George A. Kern, M.D., supra, at pp. 5-7, the "reason to know" standard attaches where: (1) a respondent has sufficient information to place him, as a reasonable medical provider, on notice that the claims presented were for services not provided as claimed; or (2) a respondent has an obligation to investigate and find out whether certain services are billable under the Medicare or Medicaid programs (such as a duty which would require a respondent to verify the truth, accuracy, and completeness of claims presented). Thus, in this case, the I.G. proved that Dr. Hume was negligent. He purposely ignored Medicare and Medicaid rules and

regulations of which he had notice. He ignored pre-existing requirements or duties (such as a Medicare and Medicaid requirements to examine the claims at issue before they were presented to Medicare or Medicaid).

As I also said in Kern, supra, the "reason to know" standard requires only objective knowledge. In discussing the concept of objective knowledge, Dean Prosser, in Keeton and Prosser on Torts (Fifth Ed. 1984), states that the actor must "give to his surroundings the attention which a standard reasonable man would consider necessary under the circumstances and that he must use such senses as he has to discover what is readily apparent."

Respondent admits that he received publications which set forth rules and procedures for his participation in the Medicare and Medicaid programs. Respondent's testimony indicated that he knew that the Medicare and Medicaid programs had rules with which he needed to comply, and, further that the publications which he received contained rules and amendments to existing rules. Respondent stated that it was his assistant's duty to "read the bulletins and correct them, and to comply with what the law said." FFCL 52. As a participant in the Medicare and Medicaid programs, Respondent was obligated to make himself aware of the rules and regulations with which he was required to comply. His decision to delegate that responsibility to his assistant, which he acknowledges, evidences negligence on his part.

d. The I.G. Proved that Respondent "Should Have Known."

The I.G. also proved that Respondent "should have known" that the items or services listed as 247-270 in the Appendix to the Notice were not provided as claimed. The "should know" standard is on the opposite end of the spectrum of knowledge from the "actual knowledge" standard and is less stringent than the "reason to know" standard. See, The Inspector General v. Thuong Vo, M.D. and Nga Thieu Du, Docket No. C-45, decided August 15, 1989, at p. 20; In the Matter of The Inspector General v. Frank P. Silver, M.D., Docket No. C-19, Opinion of Deputy Under Secretary, decided April 27, 1987. The "should know" standard includes reckless disregard for the consequences of a person's acts and negligence in preparing, presenting, or 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, ___U.S.___ (1988).

The same reasons that establish that Respondent "had reason to know" also establish that Respondent "should have known."

III. The Appropriate Amount of the Penalty, Assessment, and Exclusion.

A. 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.

While the CMPL and Regulations require consideration of aggravating and mitigating factors to determine the appropriate amount of the penalty, assessment, and 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). The preamble to the Regulations states 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 CMPL is a remedial federal statute and the purpose of a civil monetary penalty in a CMPL case is deterrence, rather than retribution or punishment. See, Mayers v. U.s. Department of Health and Human Services, 806 F.2d (11th Cir. 1986), cert. denied, _____ U.S._____ (1988); see also, Chapman v. United States of America, Department of Health and Human Services, 821 F.2d 523 (10th Cir., 1987). The dual purpose of the deterrence is to

encourage others to comply with the law and to discourage a respondent from committing the wrong again.

In addition to deterrence, the ALJ must consider that the purpose of the penalty and assessment in a CMPL case is to enable the United States to recover the damages resulting from false or improper claims. This includes recovering 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). Kern, at pg.63; Vo, supra, at pg. 22. 48 Fed. Reg. 38832 (Aug. 26, 1983). See, H.R. Rep. No. 97-158, 97th Cong., 1st Sess. 329, 461-62 (1981), 1981 U.S. Code Cong. & Ad. News 727-28.

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 consider what would prevent the wrong from being committed again by a given respondent and others. Kern, supra, at p.63.[7]

The I.G. must prove, by a preponderance of the evidence, any aggravating circumstances and Respondent must prove, by a preponderance of the evidence, any mitigating circumstances. In applying these criteria, I must look at all of the claims for which liability has been established (the claims containing line items one through 246 for which liability was established prior to the hearing, as well as, the claims containing line items 247 through 270 for which liability was established as a result of the hearing).

1. The Nature and Circumstances of the Claims and Services at Issue.

The guidelines, at section 1003.106(b)(1) 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

[7] Section 1003.107 of the Regulations requires that the same criteria used in determining the penalty and assessments be used in determining the length of any exclusion.

a "short period of time" or how to evaluate the number of claims.

The guidelines at section 1003.106(b)(1) of the Regulations also 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. Kern, supra, at pg.66.

Since examples of mitigating circumstances in the guideline are couched 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. On the other hand, since examples of aggravating circumstances in the guidelines are couched 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. Here, the I.G. has established more than one.

The I.G. proved that there were several types of items and services involved. The parties stipulated to the authenticity of the procedure codes as listed in the Appendix to the Notice. There were at least five different types of services and items involved in this case.

The I.G. proved that the services and items at issue were provided over a lengthy period of time. The items and services were provided during the period December 1983 through January 1986, a period of over three years.

The I.G. proved that there were a substantial number of claims at issue. Respondent presented or caused to be presented 270 claims for items or services.

The I.G. also proved that there was a pattern of claims for such items or services. Respondent consistently presented or caused to be presented, during the winter months of 1983 through 1986, improper claims for several types of items or services.

2. The Degree of Culpability of the Respondent.

One of the most complex factors to be considered by the ALJ in determining the amount of the penalty is the "degree of culpability." 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). In this case, the degree of Respondent's knowledge ranges from one end of the "spectrum of knowledge" to the other. See Discussion at page 18.

The I.G. also proved that the amounts claimed for the items and services at issue were substantial. Respondent claimed a total of $2,474.60 for the items and services listed in line items one through 270.

The I.G. proved that Respondent knew that the items and services reflected in line items one through 246 were not provided as claimed. Respondent's November 1986 conviction, which involved the items or services reflected in line items one through 246, was for "knowingly executing or tendering, under penalty of perjury, a false affidavit or certificate given in support of a claim for compensation, thereby illegally receiving payments under the Title XIX Medicaid program in an amount in excess of one hundred dollars. . . ." Thus, Respondent had actual knowledge that the items or services claimed in line items one through 246 were not provided as claimed.

With respect to the claims containing line items 247 - 270, the I.G. did not prove by a preponderance of the evidence that Respondent knew that the items or services were not provided as claimed. The rules and regulations governing participation in the Medicare and Medicaid programs are contained in manuals and bulletins which were received by Respondent. However, Respondent testified that he did not review, or did not recall reviewing, the manuals and bulletins which he received. Respondent testified that he designated the responsibility for maintaining the manuals and bulletins, and for complying with their requirements, to his assistant, Sharon Bradberry, who rendered the services and items claimed in line items 247 through 270. He testified that he instructed Ms. Bradberry through weekly

telephone calls from Florida. The rules and regulations make it clear that the term "personal supervision" does not encompass supervision by means of telephone communications.

The I.G. proved that Respondent should have ascertained the proper definition of this key term and, thus, both had "reason to know" and "should have known" that the services or items were not provided as claimed. Also, it is an aggravating circumstance that Respondent had a reckless disregard for the Medicare and Medicaid program requirements, in that he knowingly ignored the requirements when presenting claims to Medicare and Medicaid.

The guidelines state that I should consider it a mitigating circumstance if: (1) the claim for the item or service was the result of an unintentional and unrecognized error in the process Respondent followed in presenting claims, and (2) corrective steps were taken promptly after the error was discovered. I conclude that Respondent did not prove that his presentment of claims containing line items 247 -270 was a result of unrecognized and unintentional error because he did not prove by a preponderance of the evidence that corrective steps were taken promptly after the error was discovered.

3. History of Prior Offenses.

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).

There were no such sanctions imposed against Respondent. He was convicted in 1965 of illegally dispensing controlled substances, but this conviction and the resultant sanctions had no connection to any program for reimbursement of medical services.

4. <u>Respondent's Financial Condition</u>.

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.

In this instance, the Respondent has ceased his practice as a medical provider. This decision was not prompted by the possible imposition of a severe penalty or exclusion but, as he put it, was based upon the fact that he had been in "this rat race" for fifty years and decided that he no longer wanted to pursue a medical career. Tr. 483. Thus, the imposition of a penalty and assessment would not impact his ability to continue as a health care provider.

Respondent testified that he had $25,000 in a United Federal Bank savings account; approximately $45,000 in American Federal Bank; approximately $10,000 in an United Federal checking account; an apartment building which is worth approximately $100,000 and returns rental income of approximately $1,000 to $1,200 per month. Respondent placed other evidence in the record attesting to the fact that: (1) he jointly owns his home, which is valued at $90,000; (2) he has a 1980 Chevrolet valued at approximately $500.00; (3) he jointly owns a 1985 Dodge Diplomat valued at $4,000 to $5,000; (4) he has an IRA worth approximately $400; (5) he collects Social Security benefits of $978 per month; (6) his wife collects Social Security benefits in the amount of $300 per month; and, (7) he has diamond jewelry worth approximately $250.

This evidence has convinced me that Respondent does not have the resources to pay the maximum penalties and assessments proposed by the I.G. Also, Respondent's age, physical condition, and retiree status would probably have a direct effect on his ability to accumulate the necessary resources to pay such a penalty and assessment.

5. Other Matters to be Considered as Justice Requires.

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. Regulations section 1003.106 (b) (5).

Respondent was convicted in 1965 of illegally dispensing controlled substances. A conviction for this type of offense represents a blatant disregard for the standards of the medical profession and the trust which persons place in those fortunate enough to pursue a medical career. Respondent chose to engage in a profession which directly affects the health and welfare of persons in our society. During his 1965 criminal proceeding, Respondent stated that no medical justification existed for his dispensing of the controlled substances. Respondent's statement evidences a conscious disregard for the duties and responsibilities which he chose to accept. Coupled with Respondent's 1986 conviction, Respondent's 1965 conviction is relevant and evidences Respondent's continued engagement in illegal activities related to the medical profession.

The I.G. has not proved by a preponderance of the evidence that Respondent's delegation of certain duties to his assistants while he was on vacation in Florida is an aggravating circumstance. The fact that the services were not rendered under Respondent's personal supervision addresses the issue of liability, and I have already concluded that Respondent was liable for the claims at issue based upon his failure to provide personal supervision. However, the I.G. failed to prove that: (1) Respondent's assistants were not qualified to provide the services, and (2) the services performed were of a type which could not properly be delegated to an assistant.

The I.G. did not prove 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. alleged that, in addition to the claims containing the 270 line items in this case, Respondent received an overpayment of $12,157.55, as a result of his presentment of and reimbursement for 1309 undocumented claims. However, the evidence adduced at trial was not convincing.

Finally, Respondent testified that he believed his medical records were in compliance with the requirements set forth by the Medicare and Medicaid programs. The MFCB auditor, James Jones, testified that each medical record had to contain: (1) a date of service, (2) treatment provided, (3) progress of treatment and, (4) prescriptions provided. The absence of any of the above listed items would result in MFCB's finding of an undocumented claim, even though the particular factor, such as a diagnosis, may not yet have been made by the physician. The MFCB auditor testified that most of Respondent's claims which were reviewed lacked: (1) a statement of the treatment provided, and (2) a diagnosis. The MFCB auditor was uncertain about whether a claim would be reimbursable if a physician had not yet made a diagnosis or had not provided treatment, and, therefore, had not included these factors in his records. In this case, the MFCB auditor automatically rejected and regarded as an undocumented claim any of Respondent's claims which were without one of the required factors.

The MFCB auditor who reviewed Respondent's claims admitted that he had no medical background or training. Furthermore, Respondent testified that he was not given the opportunity to explain his medical record-keeping system and was not notified of his possible violation of record keeping requirements. The I.G. did not offer the 1309 claims into evidence so that I could determine whether they were, in fact, undocumented, and, thus, should be viewed as an aggravating circumstance.

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

The I.G. in his post-hearing brief (at page 62), requested that I impose the maximum penalty of $540,000.00, the maximum assessment of $4,948.20, and a "significant program exclusion." Previously, the I.G. had proposed a penalty of $135,000, assessment of $4,948.20, and a ten-year exclusion.[8]

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[8] On November 21, 1986, in a criminal proceeding, Respondent pled guilty in the State Court for Polk County, Iowa to the charge of Fraudulent Practice in the Third Degree and was ordered to pay $1,809.97 in restitution for overpayments which he received from the Medicaid program and to pay $107.42 in restitution for overpayments which he received from the Medicare program. The I.G. proposed to allow Respondent to apply a credit (continued...)

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 maximum penalty and assessment is excessive. However, I conclude that a ten-year exclusion from participation in the Medicare and State health care programs is appropriate.

I conclude that, based on the record in this case, giving special weight to the poor health of Respondent, and based on my experience in other CMPL cases, a penalty of $73,500 is a sufficient deterrent under the circumstances of this case; an assessment of $4,948.20 is sufficient to compensate the Government; and an exclusion for a period of ten years is sufficient to ensure the integrity of the Medicare and Medicaid programs. See Kern, supra, at pp. 69-70.[9]

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[8] (...continued)
of $1,917.39 towards the amount of penalty and assessment sought. See Stip. B.5. I have considered this in my determination of the appropriate sanctions.

[9] Following the hearing, I invited the parties to address, in their reply briefs, the issue of whether the recent United States Supreme Court decision in United States v. Halper, ____U.S.____ (1989), 57 U.S.W.L. 4526(1989), is applicable to the facts of this case. Based upon my analysis of law and facts of this case, I conclude that Halper, does not apply.

In Halper, the Supreme Court held that under certain limited circumstances, the imposition of a civil money penalty may be viewed as a "punishment," and, as such, may violate the Double Jeopardy Clause of the Sixth Amendment to the United States Constitution. The initial issue to be addressed in determining the applicability of Halper to a CMPL case is whether a respondent's prior conviction was also based upon federal law and in a federal court. If the prior conviction was in a state court and based on state law the "Separate Sovereign Doctrine" would prohibit the Double Jeopardy clause from taking effect. Under the Separate Sovereign Doctrine," one sovereign, (i.e., the United States Government), is not barred from seeking a sanction against a respondent, even though another sovereign (i.e., a state government), may already have imposed sanctions against that respondent based upon the same act or crime. Dr. Hume was convicted in State Court for State law violations.
(continued...)

ORDER

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

(1) pay a civil monetary penalty of $73,500;

(2) pay an assessment of $4.948.20; and

(3) be excluded for a period of ten years from the Medicare and Medicaid programs.

/s/

Charles E. Stratton
Administrative Law Judge