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Before the
State Of Wisconsin
Board of Nursing

In the Matter of the Disciplinary Proceedings
Against Eric L. Nielsen, R.N., Respondent

FINAL DECISION AND ORDER

Order No. 0003901

Division of Legal Services and Compliance Case No. 12 NUR 368

The State of Wisconsin, Board of Nursing, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, make the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Board of Nursing.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated at Madison, Wisconsin on the 9th day of April, 2015.

Member
Board of Nursing

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings Against ERIC L. NIELSEN, R.N., Respondent	DHA Case No. SPS-14-0047 DLSC Case No. 12 NUR 368

PROPOSED DECISION AND ORDER

The parties to this proceeding for purposes of Wis. Stat §§ 227.47(1) and 227.53 are:

Respondent Eric L. Nielsen, R.N., by:

Attorney Mark R. Hinkston
Knuteson, Hinkston & Quinn, S.C.
500 College Avenue
Racine, WI 53403-1058

Wisconsin Board of Nursing
P.O. Box 8366
Madison, WI 53708-8366

Department of Safety and Professional Services, Division of Legal Services and Compliance, by:

Attorney Kim M. Kluck
Department of Safety and Professional Services
Division of Legal Services and Compliance
P. O. Box 7190
Madison, WI 53707-7190

PROCEDURAL HISTORY

On May 20, 2014, the Department of Safety and Professional Services, Division of Legal Services and Compliance (Division), filed a formal Complaint against Respondent Eric L. Nielsen, R.N., alleging that Respondent engaged in two counts of misconduct by obtaining or attempting to obtain any compensation by fraud, misrepresentation, deceit or undue influence in the course of nursing practice, in violation of Wis. Admin. Code § N 7.04(13),[1] and one count of

[1] All references to Wis. Admin. Code § N 7.04 refer to the code as it existed before August 1, 2014.

falsifying patient records[2] regarding the number of hours spent providing in-home nursing care to Client A,[3] in violation of Wis. Admin. Code § N 7.04(6). Respondent failed to file an Answer to the Complaint and, on June 10, 2014, the undersigned administrative law judge (ALJ) issued a Notice of Telephone Prehearing Conference for June 19, 2014. At the June 19 prehearing conference, Attorney Amanda Florek appeared on behalf of the Division, and Respondent appeared *pro se*. Respondent stated that Attorney Mark Hinkston was representing him; however, the ALJ was unable to reach Attorney Hinkston. The ALJ re-set the prehearing conference for July 10, 2014 and the Division indicated that it would be moving for default judgment based on Respondent's failure to file an Answer to the Complaint.

At the July 10, 2014, prehearing conference, the Division moved for default based on Respondent's failure to file an Answer. The ALJ denied the motion for default and provided Respondent with another opportunity to file an Answer. The deadline for filing the Answer was July 17, 2014. The ALJ re-set the prehearing conference for July 21, 2014.

On July 17, 2014, Respondent filed an Answer to the Complaint in which he denied most of the substantive allegations in the Complaint. At the prehearing conference held on July 21, 2014, the Division indicated it would be filing a motion to strike Respondent's Answer. The ALJ issued a briefing schedule on the motion to strike. Consistent with the briefing schedule, on July 25, 2014, the Division filed a Motion to Strike Answer and For Imposition of Costs on grounds that Respondent's denials to allegations in the Complaint were without any reasonable basis in law or equity. However, the Division and Respondent were subsequently able to reach a Stipulation of Facts filed on July 29, 2014, and the motion was withdrawn. On August 13, 2014, an additional prehearing conference was held at which a hearing on the remaining issues was scheduled for October 28, 2014.

The hearing was held on October 28, 2014 in Madison, Wisconsin, at which Attorney Hinkston appeared on Respondent's behalf. Respondent did not appear. Post-hearing briefing was ordered, with the Division's brief-in-chief due by November 25, 2014, Respondent's brief due by December 15, 2014, and the Division's reply brief due by December 26, 2014.

On December 26, 2014, the Division of Hearings and Appeals (DHA) contacted the Division, informing the Division that DHA had not received the Division's brief. On December 29, 2014, the Division responded by email, indicating that there had been an oversight in mailing the brief, which the Division believed was sent to DHA and Attorney Hinkston's office on November 18, 2014. The Division confirmed that Attorney Hinkston, like DHA, had not received the brief. Attorney Hinkston agreed to an extension of December 30, 2014 for the Division to file its brief and the parties agreed to ten business days for Attorney Hinkston to file a response. On December 30, 2104, the Division filed its brief with DHA. Respondent did not file a response.

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[2] The Complaint actually alleged falsifying "nursing reports;" however, the Division cited Wis. Admin. Code § N 7.04(6) which addresses falsifying "patient records." There is no dispute here that the Nurse Visit Reports at issue constituted "patient records" under Wis. Admin. Code § N 7.04(6).

[3] The Division referred to the client at issue in the Complaint as "Client A" to maintain confidentiality of the individual's identity. During testimony, the witnesses and attorneys referred to the client by her initials, "S.P." All documentary exhibits contain the client's full name. This decision refers to the client as Client A.

FINDINGS OF FACT

1. Respondent Eric L. Nielsen, R.N., (DOB November 15, 1970) is licensed in the State of Wisconsin to practice professional nursing, having license number 119245-30, first issued on March 15, 1995 and current through February 29, 2016. (Complaint ¶ 1; Answer ¶ 1)

2. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 213 West Beltline Highway, Apartment 24, Madison, Wisconsin 53713. (Complaint ¶ 2; Answer ¶ 2)

3. In March and April of 2012, Respondent provided home nursing care to Client A at Client A's home in Waukesha, Wisconsin. Respondent was responsible for accurately tracking and submitting his claims for payment for these services to the State of Wisconsin Medicaid program. Claims are submitted electronically through the ForwardHealth website portal, a website used by the Medicaid program. (Complaint ¶ 3; Answer ¶ 3; Hrg. Trans., pp. 29-30)

4. Client A lived with her adult sister in Waukesha. Client A's medical history was significant for quadriplegia, secondary to a tumor in her spinal cord, and diabetes. Respondent was the first nurse who provided in-home nursing care to Client A. Because Client A's sister had never had in-home nursing care for Client A, she was not familiar with how the system worked or how billing was done for the services. (Ex. 2, pp. 4-5, 11)

5. On April 1, 2012, Respondent provided care to Client A in her home for four hours, from 11:00 a.m. to 3:00 p.m. Respondent prepared a Nurse Visit Report for the care provided to Client A in which he indicated that he had actually spent ten hours providing care to Client A. Respondent then submitted a claim for payment through the ForwardHealth portal requesting payment for 12 hours of nursing care for Client A for that date. Respondent was paid for 12 hours of care based on his claim submission. (Complaint ¶ 4; Answer ¶ 4; Ex. 1, pp. 76-78, with attached Ex. 4)

6. On April 6, 2012, Respondent provided care to Client A in her home for eight hours, from 9:00 a.m. to 5:00 p.m. Respondent prepared a Nurse Visit Report for the care provided to Client A in which he indicated that he had actually spent ten hours providing care to Client A. Respondent then submitted a claim for payment through the ForwardHealth portal requesting payment for 12 hours of nursing care for Client A for that date. Respondent was paid for 12 hours of care based on his claim submission. (Complaint ¶ 5; Answer ¶ 5; Ex. 1, pp. 78-79, with attached Ex. 5)

7. On April 22, 2012, Respondent's employment as a private duty nurse for Client A was terminated. Following that date, Respondent did not provide any further home nursing care to Client A. (Stipulation of Facts, ¶ 1; Ex. 2, p. 8; Ex. 7)

8. After being discharged from providing further home nursing care to Client A, Respondent submitted claims for payment through the ForwardHealth portal, requesting payment for 12 hours for home nursing care services for Client A for each of the following 23 dates:

April 25, 26, 27, 28 and 29, 2012; and May 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24 and 25, 2012.

9. All of Respondent's billing for April and May of 2012 were submitted on May 11 and May 25, 2012. On May 11, 2012, Respondent submitted claims for payment for the dates of April 22, 25, 26, 27, 28, 29 and May 2, 3, 4, 5, 6, 9, 10 and 11. On May 25, 2012, Respondent billed for the dates of May 12, 13, 16, 17, 18, 19, 20, 23 and 24. (Ex. 3).

10. Respondent knew that the maximum number of hours he could bill for one service date was 12 hours and that the maximum billable hours for one week was 60 hours. On every one of these dates, Respondent claimed the maximum amount he could for the day. (Ex. 1, p. 46; Ex. 3; Hrg. Trans., p. 18)

11. Medicaid paid Respondent for 12 hours of care for each of those dates based on his claim submission. Respondent received these payment checks within a week or two after submitting the claims. Payment checks were accompanied by Remittance Advice sheets which described what dates of service were included in the payment check. (Ex. 1, pp. 46-48; Ex. 3; Hrg. Trans., p. 17; Stipulation of Facts, ¶¶ 2, 3, 4, 5, 6)

12. Respondent cashed all of the checks he received from the Medicaid program. (Ex. 1, p. 55).

13. The process of submitting a claim to Medicaid through the portal involves a sign-in with a username and password. The provider then selects to submit a claim and chooses what type of claim to be submitted. The provider is then directed to a claim form appropriate to the services rendered to input all of the required information. (Hrg. Trans., pp. 29-31)

14. There are a number of data fields in which Respondent had to input data for his claims submissions. In order to move from one field to another after entering data, Respondent needed to tab forward with each piece of data. After entering all the necessary data for a particular date of service, Respondent would then have had to hit "enter" for that line of data. Each date of service would have been entered as a separate line of data because Respondent entered his claims as single dates of service. (Hrg. Trans., pp. 31-32)

15. For April and May 2012, Respondent himself submitted his own claims to Medicaid through the ForwardHealth portal. Respondent submitted each date-of-service claim through the portal individually. Client A was Respondent's only client for April and May of 2012. (Ex.1, pp. 29, 45; Hrg. Trans. pp. 30-32)

16. Respondent was very familiar with how to submit claims for payment through the portal because he had been doing it for over 15 years. He had never had difficulty submitting claims through the portal and had never been confused or uncertain as to how to submit claims through the portal. If he had any questions on how to do so, he knew that the billing guidelines were online and updated. (Ex. 1, pp. 14-15, 23-24)

17. Respondent's submissions for each date of service through the portal required eight keystrokes to tab forward to each of the following data fields: (1) from date of service; (2) to date of service; (3) procedure code; (4) modifiers; (5) diagnosis; (6) units; (7) charge; and (8) place of service. He then had to hit "enter" to move to the next line of data. (Hrg. Trans., p. 36; Ex. 10, pp. 11-12)

18. The longest period of time between Respondent's alleged service date for Client A and the date that he submitted the claim through the portal was 19 days. That lapse of time was from April 22, 2012 (the date he represented that he performed nursing work) to May 11, 2012 (the date that he submitted the claim through the portal to request payment). The shortest period of time between the date he represented that he performed work to the date he submitted the claim for payment was hours or minutes. On May 11, 2012, Respondent submitted a claim for payment for work he represented that he performed on May 11, 2012. (Ex. 3)

19. In order to be able to bill Medicaid for work, providers such as Respondent first submit an application to Wisconsin Department of Health Services (DHS). As a part of the application process, Respondent had to sign the DHS Wisconsin Medicaid program provider agreement and sign an affidavit acknowledging that he would comply with the written policy for the Medicaid program. Respondent knew that he was permitted to bill only for services that he actually rendered, and to bill the correct number of hours for services rendered. (Ex. 1, pp. 26-27)

20. DHS's Office of the Inspector General (OIG) the agency responsible for reviewing potential fraud on the Medicaid system. (Hrg. Trans., p. 12)

21. Medicaid audits are initiated by the OIG based on complaints submitted, Medicare alerts, and data analyses that identify either billing irregularities or providers with high numbers of denied claims. (Hrg. Trans., pp. 14-15)

22. OIG initiated an audit of Respondent for his billing related to Client A based on a complaint received by OIG. A letter request for documentation was sent to Respondent twice and Respondent refused to respond to either letter with the requested documentation. OIG determined that the total amount of claims submitted by Respondent for services he did not provide was $14,906.65. Respondent has not repaid any of this amount. (Ex. 3; Hrg. Trans., pp. 18-20, 24-27)

DISCUSSION

Burden of Proof

The burden of proof in disciplinary proceedings is on the Division to show by a preponderance of the evidence that the events constituting the alleged violations occurred. Wis. Stat. § 440.20(3); *see also* Wis. Admin. Code § HA 1.17(2). To prove by a preponderance of the evidence means that it is "more likely than not" that the examined action occurred. *See State v. Rodriguez*, 2007 WI App. 252, ¶ 18, 306 Wis. 2d. 129, 743 N.W.2d 460, citing *United States v. Saulter*, 60 F.3d 270, 280 (7th Cir. 1995).

Violations

Following an investigation and hearing, the Board may discipline a registered nurse if it concludes that the nurse has committed one or more violations of Chapter 441, Subchapter I, of the Wisconsin Statutes or of any rule adopted by the Board under the authority of that subchapter, or if the nurse has engaged in "misconduct or unprofessional conduct." Wis. Stat. 441.07(1)(b) and (d), respectively (2011-2012). The phrase "misconduct or unprofessional conduct" is defined as "any practice or behavior which violates the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient or the public" and includes "[f]alsifying or inappropriately altering patient records," and "[o]btaining or attempting to obtain any compensation by fraud, misrepresentation, deceit or undue influence in the course of nursing practice." Wis. Admin. Code § N 7.04(6) and (13), respectively.

The Division alleges that Respondent engaged in one count of misconduct under Wis. Admin. Code § N 7.04(6), by falsifying nursing reports regarding the number of hours spent providing in-home nursing care to Client A, and two counts of misconduct of Wis. Admin. Code § N 7.04(13), by obtaining or attempting to obtain any compensation by fraud, misrepresentation, deceit or undue influence in the course of nursing practice. These violations are examined in turn.

Respondent falsified patient records, in violation of Wis. Admin. Code § N 7.04(6).

The Division states that Respondent falsified Client A's patient records on April 1 and 6, 2012.[4] On April 1, Respondent provided care to Client A in her home for four hours, from 11:00 a.m. to 3:00 p.m. Respondent prepared a Nurse Visit Report of the care provided to Client A, in which he indicated that he had actually spent ten hours providing care to Client A on April 1. Respondent then submitted a claim for payment though the ForwardHealth portal requesting payment for 12 hours of nursing care for Client A for that date. He was paid for 12 hours of care based on his claim submission.

On April 6, 2012, Respondent provided care to Client A in her home for eight hours, from 9:00 a.m. to 5:00 p.m. Respondent prepared a Nurse Visit Report for the care provided to Client A in which he indicated that he had actually spent ten hours providing care to Client A on April 6. Respondent then submitted a claim for payment through the ForwardHealth portal requesting payment for 12 hours of nursing care for Client A for that date. Respondent was paid for 12 hours of care based on his claim submission.

For both dates, Respondent falsely documented that he performed more work than he actually did. In addition to the false documentation of work hours, Respondent then fraudulently submitted claims to Medicaid for 12 hours of care for each date, April 1 and 6, 2012.

This information is sufficient to support the conclusion that Respondent falsified Patient A's records, particularly as there is nothing in the record to indicate otherwise.

[4] It is unclear how the Division determined that one count should be charged for this conduct.

Respondent obtained compensation by fraud, misrepresentation or deceit in the course of nursing practice, in violation of Wis. Admin. Code § N 7.04(13).

The Division also charged Respondent with two counts of misconduct or unprofessional conduct as defined by Wis. Admin. Code § N 7.04(13), by obtaining compensation by fraud, misrepresentation or deceit on 23 separate occasions: April 25, 26, 27, 28 and 29; and May 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24 and 25.[5] Respondent did not appear at the hearing in this matter and did not submit a post-hearing brief as ordered. However, he has indicated at other points in these proceedings, such as during the investigative interview by the Division, that he did not know that he was making an error in submitting the claims for payments when he had not performed the work. (Ex.1, p. 49-50). Respondent has waived any such argument by failing to raise it at hearing or in post-hearing briefing. However, even if not waived, this assertion is not credible in light of the overwhelming evidence to the contrary.

In arguing that Respondent's actions constituted misrepresentation and fraud, the Division relies on the Wisconsin jury instruction for misrepresentation, which contains five elements: (1) there was a representation of fact; (2) the representation of fact was untrue; (3) the untrue representation was made knowing that the representation was untrue or was made recklessly without regard for whether it was true or false; (4) the representation was made with the intent to deceive and induce another to act upon it, to that other person's or entity's pecuniary damage; and (5) the person or entity deceived believed such representation to be true and relied on it. Wis. JI-Civil, § 2401. I agree that this framework is appropriate in analyzing the issues of fraud, representation and deceit, and also agree that all five elements are satisfied in this case.[6]

1. Respondent made a representation of fact.

Respondent submitted claims for payment to the Medicaid program through the ForwardHealth portal requesting payment for 12 hours for in-home nursing care services for Client A for each of the following 23 dates: April 25, 26, 27, 28 and 29; May 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24 and 25, 2012. Respondent was paid for 12 hours of care for each of those dates based on his claim submission. By claiming that he performed in-home nursing care services for Client A, Respondent made a representation of fact to Medicaid.

2. Respondent's representation was untrue.

As indicated above, Respondent has stipulated that on April 22, 2012, his employment as an in-home nurse for Client A was terminated and that following that date, he did not provide any further in-home nursing care to Client A. Respondent further stipulated that he requested payment and was paid for 12 hours of care for Client A on each of the 23 dates from April 25,

[5] It is unclear how the Division determined that two counts should be charged for this conduct.

[6] The Division accurately notes that the elements of fraud are virtually identical to the elements of misrepresentation. The Wisconsin Supreme Court has described the common law elements of fraud as follows: "At common law, a plaintiff alleging fraud must prove: 1) a representation of material fact; 2) the representation's falsity; 3) the intent to deceive (or reckless disregard for truth or falsity); 4) intent to defraud or to induce action; 5) justifiable reliance by the deceived party." *State v. Abbott Labs, Inc.*, 2012 WI 62, ¶52, 341 Wis. 2d 510, 816 N.W.2d 145; *see also Kaloti Enterprises., Inc. v. Kellogg Sales Co.*, 2005 WI 111, ¶12, 283 Wis. 2d 555, 699 N.W.2d 205 (misrepresentation); *Krause v. Busacker*, 105 Wis. 350, 350, 81 N.W. 406 (1900).

2012 to May 25, 2012. Thus, the submissions claiming entitlement to payment for in-home-nursing services on these 23 dates after he was fired on April 22, 2012 were untrue because he did not perform the services.

3. The untrue representation was made by Respondent knowing that it was untrue.

I do not find credible Respondent's claim that his improper billing was an unintentional mistake. Most starkly contradicting that claim is the sheer number of times Respondent submitted payments for days he did not work. This was not a situation involving one or two submissions. Rather, Respondent improperly submitted claims for payment on 23 separate occasions for work he claimed to have performed in April and May of 2012 – days following his termination from employment. For each of those 23 days, he claimed the maximum number of hours allowed, 12 hours, and he was paid for those hours claimed for each of the 23 days. Respondent knew that the maximum number of hours he could bill for one service date was 12 hours and that the maximum billable hours for one week was 60 hours.

In addition, for each of the 23 fraudulent dates of service, Respondent had to go through several distinct and deliberate steps to submit his claim. Respondent submitted his own claims to Medicaid through the portal for the 23 dates in April and May of 2012. Respondent submitted each date-of-service claim through the portal individually. Client A was Respondent's only client for April and May of 2012.

Respondent was very familiar with how to submit claims for payment through the portal because he had been doing it for over 15 years. He had never had difficulty submitting claims through the portal and had never been confused or uncertain as to how to submit claims through the portal. If he had any questions on how to do so, he knew that the billing guidelines were on-line and updated.

Respondent's submissions for each date of service through the portal required eight distinct keystrokes to tab forward to each of the following data fields: (1) from date of service; (2) to date of service; (3) procedure code; (4) modifiers; (5) diagnosis; (6) units; (7) charge; and (8) place of service. He then had to hit "enter" to move to the next line of data. In order for Respondent to submit all 23 claims (using eight keystrokes each), he needed to make at least 184 keystrokes.

Respondent contended during his investigative interview that the submissions of claims were error caused by the time that had elapsed from the date he was fired in April of 2012 until the time he actually submitted the claims to Medicaid -- months or even a year, according to Respondent. (Ex. 1, p. 50, lines 3-12) The record does not support this assertion. Rather, Respondent submitted his false claims for work for Client A within days or hours of the claimed dates of service.

The longest period of time between the alleged service date for Client A and the date that he submitted the claim through the portal was 19 days. That lapse of time was from April 22, 2012 (the date he represented that he performed nursing work) to May 11, 2012 (the date that he submitted the claim through the portal to request payment). The shortest period of time between

the date he represented that he performed work to the date he submitted the claim for payment was hours or minutes. On May 11, 2012, Respondent submitted a claim for payment for work he represented that he performed on that same date, May 11, 2012.

Finally, I note that in order to be able to bill Medicaid for work, providers such as Respondent must first submit an application to DHS. As a part of the application process, Respondent had to sign the DHS Wisconsin Medicaid program provider agreement and sign an affidavit acknowledging that he would comply with the written policy for the Medicaid program. Respondent knew that he was permitted to bill only for services that he actually rendered, and to bill the correct number of hours for services rendered.

4. The representation was made with the intent to deceive and induce Medicaid to act upon it, to Medicaid's pecuniary damage.

Respondent knew that his submission of claims through the portal would result in payment of money from the Medicaid program. As stated, he had been doing it that way for over 15 years.

Respondent submitted 23 fraudulent claims on May 11 and 25, 2012. Medicaid processed the claims and made payment to him. Respondent received payment checks within a week or two after submitting the claims. Payment checks were accompanied by Remittance Advice sheets which described what dates of service were included in the payment check. Respondent cashed all of the checks he received from the Medicaid program.

Based on the foregoing, I conclude that Respondent's representations were made with the intent to deceive and induce Medicaid to send him a check for services he did not perform, to Medicaid's pecuniary disadvantage.

5. Medicaid believed such representation to be true and relied on it.

As stated, Medicaid sent payment to Respondent for each of the 23 days at issue, obviously believing and relying on Respondent's statements that he performed the services as he stated.[7]

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[7] Relying on Wis. Stat. § 904.04(2) and case law interpreting this provision, the Division also asserts that for each of the 23 fraudulent dates of service, the other 22 dates can be used as "prior bad acts" evidence. The Division then goes on to analyze the criteria for admission of prior bad acts. This analysis is inapplicable. Not only are the standards of admissibility different for administrative proceedings, *see* Wis. Stat. § 227.45, but also, the prior bad acts framework applies to uncharged conduct, not conduct that has been alleged in the complaint and must be proven under the applicable standards of proof.

I also note that in the fact section of its brief, the Division alleges that Respondent submitted claims for the dates of April 13, 15, 18, 19 and 20, 2012, although he did not perform any services for Client A on those dates. Because the Division does not relate these additional dates to any of the alleged violations, these additional dates are not discussed in this decision.

In view of the foregoing, Respondent engaged in misconduct or unprofessional conduct under Wis. Stat. § 441.07(1)(d) (201102012) and Wis. Admin. Code § N 7.04(6) and (13).

Discipline

As a result of the violations set forth above, Respondent is subject to discipline pursuant to Wis. Stat. § 441.07(1)(b) and (d) (2011-2012). The three purposes of discipline are: (1) to promote the rehabilitation of the licensee; (2) to protect the public from other instances of misconduct; and (3) to deter other licensees from engaging in similar conduct. *State v. Aldrich,* 71 Wis. 2d 206, 237 N.W.2d 689 (1976).

The Division recommends that Respondent's professional nursing license be indefinitely suspended and that his privilege to practice as a nurse in the State of Wisconsin under the authority of another state's license pursuant to the Nurse Licensure Compact likewise be suspended for an indefinite period. The Division further recommends that the suspension not be stayed for the first six months, but that any time after six months the suspension may be stayed upon Respondent petitioning the Board and providing proof, which is determined by the Board to be sufficient, that Respondent is amenable to rehabilitation and education. The Division states that the decisions of whether to stay the suspension and whether to impose any limitations or restrictions on Respondent's license should be in the sole discretion of the Board.

Under the facts of this case, and consistent with prior Board decisions, the Division's recommendations are adopted.

Respondent has demonstrated by his conduct in fraudulently billing the Medicaid program that he cannot be trusted to provide nursing care in a home care setting where he is unsupervised and where he is responsible for billing his own nursing time. The healthcare system allocates scarce resources to provide for patient care. *In the Matter of Disciplinary Proceedings Against Sheila E. Novin, R.N.*, Order No. LS0510061NUR (April 20, 2006) (*http://online.drl.wi.gov/decisions/2006/ls0510061nur-00069649.pdf*) The Medicaid program is designed to allocate those resources. *Id.* That system necessarily requires that providers be accurate and responsible for the care that is provided and the amount that is billed for that care. *Id.* The system is built upon the trust that the providers, such as Respondent, will provide the services that they bill to the system. *Id.*

In *Novin*, the registered nurse, Sheila Novin, had previously been disciplined by the Board for a criminal fraud conviction from 1996, but was allowed to continue to practice nursing. Novin was prohibited from seeking payment from Medicaid and Medicare for any nursing services after the criminal conviction. Despite that prohibition, Novin set up businesses using another name and billed Medicaid and Medicare patients for services she and other nurses provided through her business operations. The total amount that Novin and her businesses received exceeded $1 million. Novin was charged with violating a law substantially related to the practice of nursing, in violation of Wis. Admin. Code § N 7.04(1), and with obtaining or attempting to obtain any compensation by fraud, misrepresentation, deceit or undue influence in the course of nursing practice, in violation of Wis. Admin. Code § N 7.04(13).

Following a hearing, Novin was found to have violated both rules and her license was revoked. The discipline was based in part on the fact that Novin had previously been disciplined, but had not been rehabilitated, and betrayed the trust of the Board and the public. In addition, there was no "credible attempt by the Novin to sincerely take responsibility for her actions" and Novin asserted that the convictions were the faults of others or "misunderstandings by her." Despite this claim of "misunderstandings," the hearing officer found that Novin "knew all too well how to work the system." Furthermore, there was no indication that Novin had any "remorse at all" for her actions. It was Novin's lack of remorse, her failure to accept responsibility for her actions, and her convoluted explanations which led the hearing officer to conclude that Novin was "not a candidate for rehabilitation or education."

In another case involving the same conduct as Respondent's, the Board reprimanded and limited a practical nurse's license. In the case, *In the Matter of Disciplinary Proceedings Against Kawana Hickman, L.P.N.*, Order No. 0002526 (July 11, 2013), Kawana Hickman was convicted of three counts of theft by false representation, Wis. Stat. § 943.20(1)(a) (class A misdemeanors), for conduct that occurred in 2007 and 2008. She was charged with intentionally deceiving a Wisconsin Medicaid recipient and obtaining fraudulent Medicaid payments of over $4,000. Ms. Hickman admitted to billing for services she did not provide and billing for services without appropriate documentation.

The Board reprimanded Ms. Hickman and imposed limitations on her nursing license, including no work in a home health, assisted living, agency or pool position; quarterly reports from her nursing employers; and limiting her practice to Wisconsin. Ms. Hickman was also ordered to complete, within 90 days of the date of the order, four hours of education on nursing ethics and five hours of education on the topic of professional and legal accountability.

Although the instant case is similar to *Hickman* in the type of underlying violations which gave rise to the discipline (billing for services not provided) and in that it was the first time Hickman's license had been disciplined, it is distinguishable in that Hickman admitted billing for services she did not provide and took responsibility for her actions. Respondent, on the other hand, has not. Instead, Respondent first maintained that his billing for services not rendered was a "mistake" and then ultimately refused to participate in these proceedings, by failing to attend the hearing and failing to submit a post-hearing brief as ordered.

Respondent, like Novin, has made no "credible attempt" to "sincerely take responsibility" for his actions, has claimed "misunderstandings" as the cause for the billing fraud despite the fact that he "knew all too well how to work the system," and has shown no "remorse at all" for his actions. This lack of remorse has been demonstrated not only by his false claims that his fraudulent billings were unintentional errors, but also by his refusal to cooperate with the OIG's audit, his refusal to repay any of the money to the Medicaid program, and his refusal to attend the hearing in this matter.

At this juncture, the only way to protect the public is through an indefinite suspension. If Respondent petitions the Board to stay the suspension, it will be in the discretion of the Board to determine whether Respondent is amenable to rehabilitation and education. Respondent should not be permitted to petition to lift the suspension for six months. This will serve to deter others

from engaging in fraud. If Respondent petitions to stay the suspension, the Board may then decide what conditions, limitations or education requirements should be imposed on his license to rehabilitate Respondent and protect the public. Whether Respondent has repaid any of the money to Medicaid at the time he petitions for a stay of the suspension may appropriately be considered by the Board as evidence of remorse and acknowledgement of responsibility for his misconduct.

Costs

The Division has the authority to assess costs pursuant to Wis. Stat. § 440.22. With respect to imposition of costs, factors to consider include: (1) the number of counts charged, contested and proven; (2) the nature and seriousness of the misconduct; (3) the level of discipline sought by the prosecutor; (4) the cooperation of the respondent; (5) any prior discipline; and (6) the fact that the Department is a program revenue agency, funded by other licensees. *See In the Matter of Disciplinary Proceedings against Elizabeth Buenzli-Fritz,* Order No. LS0802183CHI (Aug. 14, 2008).

Respondent has not presented any evidence regarding any of the above factors that would mitigate the imposition of the full costs of this proceeding. The factual allegations were admitted and proven and there is no argument to apportion any counts that were unproven, or that certain factual findings were investigated and litigated that were unnecessary. The underlying conduct of defrauding a publicly funded health program is serious and is a violation of the public's trust. Although Respondent has had no prior discipline in Wisconsin and was initially cooperative during the proceedings, including entering into a stipulation of facts with the Division, he ultimately abandoned the proceedings, refusing to attend the hearing or file a post-hearing brief as ordered. Finally, the Department is a "program revenue" agency whose operating costs are funded by license fees. Fairness dictates that costs be imposed upon Respondent and not fellow members of the nursing profession who have not engaged in such conduct. Based on the foregoing, full imposition of costs on Respondent is appropriate.

CONCLUSIONS OF LAW

1. The Division met its burden of establishing that Respondent engaged in misconduct or unprofessional conduct under Wis. Admin. Code § N 7.04(6) and (13), respectively, by falsifying patient records and by obtaining compensation by fraud, misrepresentation and deceit in the course of nursing practice.

2. As a result of Respondent's violations, he is subject to discipline pursuant to Wis. Stat. § 441.07(1)(b) and (d) (2011-2012).

3. The discipline imposed in the Order section below is appropriate under the facts of this case and the criteria set forth in *Aldrich.*

4. Pursuant to Wis. Stat. § 440.22 and the Board's prior decision in *Buenzli-Fritz,* Respondent should pay the full costs of this proceeding.

ORDER

For the reasons set forth above, IT IS HEREBY ORDERED that:

1. The professional nursing license issued to Respondent Eric L. Nielsen, R.N., is indefinitely SUSPENDED. The privilege of Respondent to practice as a nurse in the State of Wisconsin under the authority of another state's license pursuant to the Nurse Licensure Compact is also SUSPENDED for an indefinite period.

2. The suspension shall not be stayed for the first six months, but any time after six months the suspension may be stayed upon Respondent petitioning the Board and providing proof, which is determined by the Board to be sufficient, that Respondent is amenable to rehabilitation and education. Whether to stay the suspension and whether to impose any limitations or restrictions on Respondent's license shall be in the sole discretion of the Board.

3. Respondent shall pay all recoverable costs in this matter in an amount to be established, pursuant to Wis. Admin. Code § SPS 2.18. After the amount is established, payment shall be made by certified check or money order payable to the Wisconsin Department of Safety and Professional Services and sent to:

Department Monitor
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

4. The terms of this Order are effective the date the Final Decision and Order is signed by the Board.

IT IS FURTHER ORDERED that the above-captioned matter is hereby closed as to Respondent Eric L. Nielsen, R.N.

Dated at Madison, Wisconsin on February 20, 2015.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
5005 University Avenue, Suite 201
Madison, Wisconsin 53705
Telephone: (608) 266-7709
FAX: (608) 264-9885

By: _____
Jennifer E. Nashold
Administrative Law Judge