DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Grant Appeals Board

Office of Hearings for Civil Money Penalties

In the Matter of:	
The Inspector General,	DATE: **Dec 16, 1985**
- v. -	Docket No. C-10
Raymond C. Reynaud, M.D.,	**DECISION CR 4**
Respondent.	

DECISION AND ORDER

This is a civil money penalties, assessments, and suspension case arising from a determination by the Inspector General (I.G.) of the Department of Health and Human Services (DHHS) that the Respondent submitted 85 false or improper Medicaid claims for payment in violation of sections 1128A and 1128(c) of the Social Security Act, as amended (42 U.S.C. §§1320a-7a and 1320a-7(c)) (Act) and its implementing federal regulations (45 C.F.R. §§101.100 et seq.) (Regulations). 1/ 2/

THE LAW AND REGULATIONS

Section 1320a-7a of the Act authorizes the Secretary of DHHS to determine to impose civil money penalties and assessments against any person who has presented or caused to be presented any

1/ Both sections 1128A and 1128(c) of the Social Security Act are codified in sections 1320a-7a and 1320a-7(c) of Title 42, U.S.C., and are part of section 2105 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35, enacted on August 13, 1981), as amended by section 137(b)(26) of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248). Section 1128(c) was formerly section 1128(b), and was redesignated as a result of amendments to section 1128 in the Deficit Reduction Act of 1984 (Pub. L. 98-369 §2333(a)(1)). All references to the Act hereinafter refer to the codified sections.

2/ The Regulations were approved on July 27, 1983, and became effective on September 26, 1983. See 48 Fed. Reg. 38827 et seq. (August 26, 1983).

false or improper claims for payment under the Medicare, Medicaid, or the Maternal and Child Health Services Block Grant programs.

Section 1320a-7(c) of the Act authorizes the Secretary to determine to suspend from the Medicare and Medicaid programs any person against whom a civil money penalty or assessment has been imposed. The Act provides for written notice and the opportunity for a hearing.

The Regulations implement the provisions of the Act, delegate authority to the I.G. to make determinations regarding false or improper claims presented, and provide a right to a hearing before a federal administrative law judge (ALJ) to those respondents against whom the I.G. proposes civil money penalties, assessments, or a suspension. The I.G. has the burden of proof regarding liability and aggravating circumstances; if found liable, a respondent has the burden of proof regarding circumstances that would justify reducing the amount of the penalty or assessment, or the period of suspension. Regulations §101.114. Either party may seek review by the Secretary of an ALJ's decision and order and may seek judicial review of any decision and order that has become final. Regulations §§101.125, 101.127.

BACKGROUND

In this case, by letter dated November 27, 1984, the Deputy I.G. for Civil Fraud notified the Respondent, a psychiatrist practicing in San Jose, California, of the I.G.'s intent to impose civil money penalties and assessments against him in the amount of $90,000 and to suspend him from participation in the Title XVIII (Medicare) and Title XIX (Medicaid) programs for a period of five years. The I.G.'s notice of intent was based on a determination that the Respondent had presented or caused to be presented 85 false or improperly filed claims for Medicaid payment for services that were not provided as claimed, in violation of the Act and Regulations, for the period between November 28, 1979 and February 29, 1980. 3/ 4/ 5/

3/ Section 1320a-7a(a)(1) of the Act defines a false or improperly filed claim to be a claim for an item or service which the person knows or has reason to know was not provided as claimed.

4/ Section 1320a-7a(h)(2) of the Act and §101.101 of the Regulations define a "claim" 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.

5/ Section 1320a-7a(h)(3) of the Act and §101.101 of the Regulations define an "item or service" to include any item, device, medical supply or service claimed to have been provided to a patient and listed in an itemized claim for payment.

By letter dated December 26, 1984, the Respondent, through counsel, requested a hearing before an ALJ pursuant to section 101.109(b)(2) of the Regulations. A prehearing conference was held in San Francisco, California on March 1, 1985 at which time prehearing procedures, opportunities for discovery, and due process rights under the Regulations and Act were discussed and a schedule was set forth regarding discovery, exchanges of documents, motions and preparation for the hearing.

A formal hearing was held in San Francisco, California from June 18, 1985 to June 21, 1985 at which time the parties were afforded a full opportunity to present and have relevant evidence entered into the record, to present and cross-examine witnesses, and to present statements, motions and argument, as provided by the Act and Regulations. The parties were represented by counsel at the hearing and were given the opportunity to submit post-hearing written briefs and proposed findings of facts and conclusions of law.

Since all of the claims in issue were presented or caused to be presented prior to the effective date of the Act, August 13, 1981, the Respondent argues that this case cannot be heard and decided administratively, by reason of the Federal Constitution, but rather, must be heard and decided by an Article III Federal Court.

ISSUES

The principal issues are:

1) Whether the Act and Regulations provide for civil money penalties and assessments for false or improperly filed claims presented prior to the effective date of the Act (August 13, 1981).

2) Whether the Act and Regulations avoid potential constitutional conflicts by guaranteeing that the amount of civil money penalties and assessments be no greater than those which could have been imposed under the False Claims Act (for pre-August 13, 1981 claims).

3) Whether the Act and Regulations provide for a suspension if civil money penalties and assessments are imposed solely on the basis of pre-August 13, 1981 claims.

4) Whether the doctrine of collateral estoppel or the doctrine of equitable estoppel bar this action.

5) Whether the Act and Regulations guarantee the parties due process rights.

6) Whether the I.G. presented clear and convincing evidence that the Respondent knowingly presented or caused to be presented claims for Medicaid payment for services that were not provided as claimed, in violation of the Act and Regulations.

7) Whether the amount of the proposed penalties, assessments, and suspension is reasonable and appropriate under the circumstances of this case, within the intent and meaning of the Act and Regulations.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having considered the entire record, the arguments of the parties, and being advised fully herein, I make the following Findings of Fact and Conclusions of Law: 6/

1. The Respondent, Raymond L. Reynaud, M.D., is a psychiatrist licensed in the State of California, has participated in the California Medicaid program (Medi-Cal) since at least 1973 and has filed claims for Medi-Cal reimbursement. I.G. Ex 1; I.G. Ex 87/16; I.G. Ex 90; I.G. Ex 2 to 86. 7/

2. On November 27, 1984, the I.G. notified the Respondent that he determined that the Respondent had submitted or caused to be submitted 85 false claims for Medicaid reimbursement in violation of the Act and Regulations and that he proposed penalties and assessments and suspension from participation in the Medicare/Medicaid programs. I.G. Ex 1; Stip. 1.

3. The California Department of Health Services (CDHS) is (and for all relevant periods was) the Medicaid agency for the State of California, authorized to administer Medi-Cal, and, until May 31, 1980, Blue Shield of California (BSC) was the fiscal intermediary for the Medi-Cal program. Stip. 3; Tr 1/51.

6/ In arriving at these Findings and Conclusions, I examined each of the proposed findings and conclusions offered by the parties. I rejected some because they were not supported by the record, others because they were not material, and some I have incorporated elsewhere in this Decision.

7/ References to record Exhibits, Stipulations and the Transcript are as follows:

Respondent's Exhibit	=	R Ex/(page number)
I.G. Exhibit	=	I.G. Ex/(page number)
Joint Exhibit	=	J Ex/(page number)
Transcript	=	Tr (volume/page number)
Stipulations	=	Stip. (number)

4. BSC received, reviewed and processed claims for care rendered to Medi-Cal beneficiaries by providers of services; these claims are subject to specific requirements governing said filing of claims for Medi-Cal reimbursement; judicial notice was taken of the relevant provisions of Title 22 of the California Administrative Code (C.A.C.). Tr 1/146, 151.

5. To ensure compliance with its regulations or requirements, Medi-Cal routinely issued educational bulletins to all eligible providers for the purpose of highlighting and clarifying the C.A.C. Tr 1/80; I.G. Ex 94B/42:

(a) As a participant in the Medi-Cal program, the Respondent was sent the Medi-Cal bulletins and was familiar with the relevant rules and regulations of the Medi-Cal program. Tr 1/80; I.G. Ex 87.

(b) Each claim submitted to Medi-Cal for reimbursement must contain the name, address and Medi-Cal provider number of the provider submitting the claim, proof of eligibility of the beneficiary, a proper coded description of the services provided, the dates the services were provided, the place of service, signature of the provider, and the charge for the services provided. Tr 1/55-56; 1/60-61.

(c) Any medical provider is required to sign the claim, certifying that all the information on the billing form is true, accurate, and complete. The certification statement reads:

> I certify that the services listed on this form were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction.
>
> This is to certify that all information entered on this form is true, accurate and complete.
>
> I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable federal or state laws.

Tr 1/57-59; I.G. Ex 94B/75; I.G. Ex 103.

(d) Medi-Cal benefits eligibility is demonstrated by attaching a proof of eligibility (POE) label or Medi-Cal sticker to the claim form and POE labels or Medi-Cal stickers are issued to all Medi-Cal beneficiaries on a monthly basis. This label or sticker will indicate the month and year that the patient is eligible to receive benefits. Tr 1/56-57.

6. On each of the Medi-Cal claims in issue in this action, the Respondent signed the certification statement referenced above. I.G. Ex 2-86.

7. The coded description of services provided to a beneficiary is derived from the California Relative Value Studies (CRVS), published by the California Medical Association (CMA). I.G. Ex 98. Services provided to Medi-Cal beneficiaries are billed using a procedure number from the 1974 Edition of the CRVS. The payment is based on the unit value from the 1969 CRVS. Tr 1/71-72; I.G. Ex 93A/69:

(a) Psychiatric services, including both individual and group therapy, are covered by the CRVS coding system. Individual psychotherapy is billed in time increments of 15, 25, and 45-50 minutes and by location (office, hospital or other facility, or home). Group psychotherapy is billed for maximum size groups of 8 or 16 persons, and it is billed for each person, in 45-50 minute or 90 minute sessions. As with individual therapy, CRVS codes also specify the location of the group session. I.G. Ex 98/6.

(b) The correct CRVS code to use when billing for 45-50 minutes of individual psychotherapy in the office is 90803; 90805 represents the same amount of time spent with an individual in his home. Tr 1/72; I.G. Ex 98/6.

(c) If a psychiatrist spends 25 minutes with an individual in his home, the proper code number is 90808; 15 minutes of individual therapy in the patient's home is billed as 90813; sessions lasting less than 15 minutes are billed under CRVS code 90440. I.G. Ex 98/4, 5; Tr 1/73; I.G. Ex 98/6; Tr 2/11.

(d) Reimbursement for 50 minutes of psychotherapy is higher than for 15 minutes. The 1969 CRVS assigns a unit value of 50 to a 50 minute psychotherapy session, while a 15 minute session carries a unit value of only 20. I.G. Ex 98/2.

(e) CRVS code 90440 is defined as a brief examination and in the psychiatric context involves simply meeting the patient and observing him in a brief interaction; reimbursement by Medi-Cal for a brief visit is considerably less than for 50 minutes of psychotherapy. Tr 2/13.

(f) Billing Medi-Cal for group therapy is as follows: A 45-50 minute session with a maximum of 8 patients in the office is billed as 90815; the same session conducted outside the

office must be billed as 90816. A group session of 45-50 minutes involving up to 16 patients in the doctor's office is billed as 90821, and as 90822 when conducted in a group home or elsewhere. I.G. Ex 98/6.

(g) Group therapy cannot be billed under 90803 or 90805, as these codes are limited to one-on-one therapy. Tr 1/77; 2/9-10; I.G. Ex 98/6.

(h) In neither group nor individual therapy can sessions be billed cumulatively. In order to bill for 45-50 minutes of psychotherapy, the therapy must have been given in one session and not accumulated over a series of shorter sessions. Tr 1/77-78; 2/14-15; I.G. Ex 94B/11-12; I.G. Ex 93A/76, 96.

(i) If a psychiatrist chooses to see the patient for a series of brief visits, the sessions must be billed separately by each date of service using the appropriate CRVS code to indicate the location and the amount of time spent with the patient. Tr 1/77-78; I.G. Ex 94B/11-12, 38-39.

8. The Medi-Cal program limits reimbursement for psychotherapy to the time spent in actual face-to-face interaction between the psychiatrist and the patient:

(a) The provider may not bill Medi-Cal for telephone consultations or for a review of the patient's records, activity logs or other documents. I.G. Ex 94B/13, 27; I.G. Ex 93A/76, 100-101; Tr 2/9; I.G. Ex 104.

(b) Consultant services provided by a psychiatrist to a board and care home or residential facility may not be billed to Medi-Cal. Tr 1/78; 2/9-10; I.G. Ex 93A/76; I.G. Ex 94B/39-40.

(c) A psychiatrist's discussions with a facility operator concerning a particular patient or the planning of the facility's general Medi-Cal program may not be billed to Medi-Cal as psychotherapy. I.G. Ex 93A/76; Tr 1/79-80.

9. The Medi-Cal program, pursuant to federal standards, requires providers to retain documentation that substantiates the services for which reimbursement is claimed (42 C.F.R. §431.107):

(a) Medi-Cal providers are required to keep, maintain and have readily retrieveable such records as are necessary to fully disclose the type and extent of services provided to a Medi-Cal beneficiary. Title 22, §51476, C.A.C.

(b) Providers of psychological services to Medi-Cal beneficiaries are required to keep and maintain patient logs, appointment books or similar documents showing the date and time allotted for appointment of each patient or group patients and the time actually spent with such patients. Id. §51476(f).

(c) Record keeping requirements protect the integrity of the Medi-Cal program and are consistent with accepted psychiatric practice. At a minimum, a psychiatrist would be expected to keep a record of the patient's visit, any medication prescribed and any significant observations bearing on the patient's diagnosis or progress and treatment. Tr 2/13-14.

10. Respondent failed to maintain and keep sufficient documentation to disclose the type, extent, and duration of services provided to Medi-Cal beneficiaries. I.G. Ex 87/13-14, 17, 22. This was also evidenced by his failure to produce documents sought by the I.G. in discovery, as ordered by me.

11. During the period in issue here, Respondent's practice was devoted primarily to providing psychiatric services to Medi-Cal beneficiaries. His patients were largely developmentally disabled individuals living in residential care facilities (also called board and care homes) which provide care and supervision in a community setting in Santa Clara County, California. Tr 1/97, 99; I.G. Ex 87/16, 23.

12. During the period of time that Respondent participated as a Medi-Cal provider he treated residents of at least twenty-three board and care homes. I.G. Ex 88/53, 54, 57-59, 62, 93-95, 97.

13. In 1979, the California Department of Justice initiated an investigation of the Respondent's billing practices and placed the Respondent under surveillance over a six month period from August 22, 1979 to February 29, 1980. Tr 1/96, 99-111, 118-119; I.G. Ex 88/7-41:

(a) Based on the results of the State's investigation, the State of California filed a criminal complaint against the Respondent on November 18, 1980 charging him with ten felony counts of filing false claims and one felony count of grand theft. I.G. Ex 96; I.G. Ex 93A-F; I.G. Ex 88/128.

(b) After the complaint (I.G. Ex 96) was filed against the Respondent, the Department of Justice received another complaint that he was taking Medi-Cal stickers from board

and care home residents who were not his patients. Tr 2/29-30; I.G. Ex 89.

(c) An investigation conducted in October 1981 revealed that in September 1981 the Respondent had visited a board and care facility for a total of thirty minutes, but had submitted eight claims for one hour and one claim for fifteen minutes of psychotherapy on behalf of residents of the home. Tr 2/29-33.

(d) The State of California filed a second criminal complaint against the Respondent charging him with seven felony counts of presenting false claims. I.G. Ex 95; Tr 2/33; I.G. Ex 94A-D.

(e) On October 20, 1983, the Respondent was convicted on four counts of presenting false Medi-Cal claims in violation of the California Welfare and Institutions Code §14107. Each claim was for fifty minutes of psychotherapy rendered at the patient's home. Stip. 9; I.G. Ex 95.

14. A major portion of the Respondent's patients (in issue here) are Medi-Cal beneficiaries residing at four residential care facilities owned by Freda Farris and located in San Jose (177 South 12th Street and 119 South 13th Street) and Santa Clara (1206 Main Street and 1264 Lincoln Street), California. I.G. Ex 88/65-68.

15. During the relevant time period, the Respondent exhibited the following pattern of practice at the Farris facilities:

(a) Once a month the Respondent held meetings with residents of the four Farris board and care facilities. One meeting was in Santa Clara at 1206 Main Street with the residents of that facility and the residents of 1264 Lincoln Street. Tr 1/152; I.G. Ex 88/73.

(b) The other meeting was in San Jose at either 177 South 12th Street or 119 South 13th Street with the residents of both facilities. I.G. Ex 88/44, 47; I.G. Ex 93D/121.

(c) For the period in issue, the Respondent visited each of the two Farris facilities for 15 minutes to one and one half hours. Tr 1/156; I.G. Ex 88/44-48, 49-51, 55-63, 71, 73-74, 117-118; I.G. Ex 93C/118; I.G. Ex 93D/84-85, 121-122, 139-140.

(d) For the period in issue, the monthly visit to the Farris facilities was the only time the Respondent saw the residents, except for Kathy Marsh whom he saw one time at his office. I.G. Ex 3, 88/27-28, 44, 47, 50, 75; Tr 1/152, 159, 195; I.G. Ex 93D/139; I.G. Ex 3.

(e) For the period in issue, the Respondent would not spend more that 5 to 10 minutes with each individual resident during the monthly session at a Farris home. I.G. Ex 88/ 8, 10, 15-16, 25, 30-31, 41, 44; I.G. Ex 93D/26.

(f) For the period in issue, at the monthly meetings at the Farris homes, the Respondent collected Medi-Cal cards or the stickers of each of the residents, whether or not that resident attended the meeting. Tr 1/157-158; I.G. Ex 93D/14, 27, 141; I.G. Ex 88/20, 32, 68, 74.

(g) Each of the managers of the Farris homes made and kept a record of medical appointments outside the home for the residents of each home. I.G. Ex 88/ 8, 14, 45, 48, 51, 67, 70, 72; Tr 1/103, 153, 167; I.G. Ex 93C/120-121; I.G. Ex 93D/15, 28.

(h) The managers of the Farris homes did not make office appointments with the Respondent for any residents on dates the Respondent claimed to have rendered services to residents of these homes in his office. Tr 1/154-155; I.G. Ex 88/46, 51, 67; I.G. Ex 92; I.G. Ex 93C/ 120-121; I.G. Ex 93D/142.

(i) The only time the Respondent saw the residents of 177 South 12th Street and 119 South 13th Street during the month of August 1979 was at a forty-five minute group meeting attended by thirteen residents on August 22, 1979, at a board and care facility. Tr 1/99-103; I.G. Ex 88/7-8, 44-51, 67, 120-121; I.G. Ex 93C/117-124; I.G. Ex 93D/ 81-82, 84, 121, 139, 142.

(j) The only time the Respondent saw the residents of 177 South 12th Street and 119 South 13th Street during the month of October 1979, was at a twenty-three minute group meeting attended by seventeen residents of the 13th Street facility. I.G. Ex 88/9-10, 44-51, 67, 120-121; I.G. Ex 93C/117-124; I.G. Ex 93D/81-82, 84, 121, 139, 142.

(k) The only time the Respondent saw the residents of 1206 Main Street and 1264 Lincoln Street during the month of November 1979, was at a twenty-six minute group meeting attended by six residents on November 14, 1979 at a board and care facility. Tr 1/51-155, 159; I.G. Ex 88/ 13-18, 27-28, 75.

(l) Other than Kathy Marsh, the only time the Respondent saw the residents of 119 South 13th Street and 177 South 12th Street during the month of November 1979, was at a forty-six minute group meeting attended by eighteen residents on November 14, 1979 at a board and care home. I.G. Ex 88/15-17, 44-51, 67, 120-121; I.G. Ex 93C/117-124; I.G. Ex 93D/81-82, 84.

(m) Kathy Marsh had an appointment to see the Respondent on November 20, 1979. I.G. Ex 88/46. Yet the Respondent submitted a claim that he had rendered services to Ms. Marsh on November 29, 1979. I.G. Ex 3.

(n) The only time the Respondent saw the residents of 177 South 12th Street and 119 South 13th Street during the month of December 1979, was at a thirteen-minute group meeting at a board and care facility on December 13, 1979. I.G. Ex 88/21-22, 44-51, 120-121; I.G. Ex 93C/117-124; I.G. Ex 93D/81-82, 84.

(o) The only time the Respondent saw the residents of 1206 Main Street and 1264 Lincoln Street during the month of December 1979, was at a thirty-six minute group meeting attended by sixteen residents at a board and care facility on December 13, 1979. Tr 1/152-155, 159; I.G. Ex 88/20-21, 25, 27-28, 75.

(p) The only time the Respondent saw the residents of 177 South 12th Street and 119 South 13th Street during the month of January, 1980, was at a thirty-six minute group meeting attended by fourteen residents at a board and care facility on January 9, 1980. I.G. Ex 88/29-31, 44-51, 120-121; I.G. Ex 93C/117-124; I.G. Ex 93D/67, 81-82, 84.

(q) The only time the Respondent saw the residents of 1206 Main Street and 1264 Lincoln during the month of January 1980, was at a forty-two minute group meeting attended by eleven residents at a board and care facility on January 9, 1980. Tr 1/152-153, 155, 159; I.G. Ex 88/29, 31-32, 75.

(r) On January 28, 1980, the Respondent did not go to any of the board and care facilities where he claimed to have rendered services that day. I.G. Ex 68-74; I.G. Ex 88/33.

16. The Respondent submitted forty-eight separate claims to Medi-Cal for psychotherapy provided during the period of January 30 to February 6, 1980 (R Ex TT/640-643), when he was out of town and unavailable for consultation. I.G. Ex 88/33-34.

17. On February 19, 1980 the Respondent did not go to any of the four board and care facilities where he claimed to have provided services that day. I.G. Ex 75, 76, 78-80; I.G. Ex 88/35.

18. On February 20, 1980 the Respondent did not go to any of the five board and care homes which he represented to have visited that day. I.G. Ex 81, 82, 84, 85; I.G. Ex 88/35-36.

19. The Respondent did not go to his office or to any of the six addresses where he represented to have provided services on February 21, 1980. I.G. Ex 23-25, 40, 41, 67; I.G. Ex 88/36-37.

20. The Respondent did not go to any of the three board and care homes where he represented to have provided services on February 29, 1980. I.G. Ex 54, 66; I.G. Ex 88/39-40.

21. The Respondent received the resident's Medi-Cal stickers in exchange for his services as consultant to the various board and care homes. I.G. Ex 88/20, 53-55, 66, 68.

22. Respondent knowingly misrepresented on his Medi-Cal claims the services provided by him. I.G. Ex 87/3, 6-8, 21, 25; Tr 1/80.

23. Eighty-two of the eighty-five claims (I.G. Ex 2-86) in issue contain services which were not provided as claimed.

24. The I.G. did not prove by clear and convincing evidence that the following claims for services were falsely claimed: (a) I.G. Ex 7. (b) I.G. Ex 77. (c) I.G. Ex 83. See Discussion, infra., p 33.

25. From June 8, 1973 through May 30, 1980, the Respondent was overpaid a total of $92,559.93 by Medi-Cal and Medicare for billings for services to residents of six board and care homes. Tr 2/19-25; I.G. Ex 88/124-129; I.G. Ex 90.

26. Based on the two criminal complaints and his felony conviction on October 20, 1983, the California Board of Medical Quality Assurance took the following action:

(a) They charged the Respondent with (1) submitting one hundred and thirty two claims to Medi-Cal, each for forty five to fifty minutes of individual psychotherapy provided either in the patient's home or in the Respondent's office, when

in fact he either conducted brief monthly visits at custodial care facilities or provided no therapy at all; and (2) signing and submitting Medi-Cal claims, knowing them to be false. I.G. Ex 105; I.G. Ex 106.

(b) The Respondent's license to practice medicine was revoked and revocation was stayed for a five year probation period upon Dr. Reynaud's admission to all the charges contained in I.G. Ex 105, 106. I.G. Ex 107/2-3.

27. The entire record proves that the Respondent knew that the services for which he sought reimbursement in 82 out of the 85 claims in issue here were not provided as claimed and that the Respondent intended to defraud the Medicaid system. See I.G. Ex 1 to 86.

28. The Respondent has a responsibility under the Act and Regulations to be informed of the regulatory requirements and was in fact, knowledgeable of them. I.G. Ex 88. See United States v. Cooperative Grain and Supply Co., 476 F.2d 47 (8th Cir. 1973). This responsibility or duty includes an obligation to ensure that the services billed for were in fact provided as claimed.

29. Had the services for which payment was sought been provided as claimed by the Respondent, they would have been reimbursable services under Title XIX of the Act.

30. Each of 82 of the 85 claims alleged by the I.G. as constituting a false claim in this case is an item or service subject to a determination under Section 101.102 of the Regulations:

(a) Each claim in issue states that 45-50 minutes of individual psychotherapy was conducted when in fact the Respondent conducted brief monthly visits at custodial care facilities or provided no individual psychotherapy at all and each claim is signed by the Respondent.

(b) The I.G. has met his burden of proving by clear and convincing evidence that Respondent is liable under the Act and Regulations for the filing of 82 false claims. (Regulations §101.114(b).)

31. The I.G. has met his burden of proving the existence of substantial aggravating factors in this case:

(a) The nature of the claims in this case and the circumstances under which they were presented are

aggravating circumstances and I.G. Ex 2-86 (except for 7, 77, 83) represent a large number of claims over such a short period of time.

(b) The I.G. has established the existence of a clear pattern of filing claims for services which were not rendered by the Respondent as claimed.

(c) The pattern of filing false claims was a conscious one, created and implemented by the Respondent, and he intended to defraud the Medicaid system or program.

(d) The amounts falsely claimed by the Respondent for the charged items and services are substantial for the short period in issue.

(e) The Respondent devised a broad scheme to obtain Medicaid reimbursement to which he was not entitled and the claims in issue are only a portion of that scheme.

(f) Knowledge and intent to file false claims is determined from the Respondent's actions in filing claims for services he knew were not rendered as claimed, from the record, and from reading his interview.

(g) The Respondent consciously sought to mislead Medi-Cal, the State, and the Federal Government, in order to cover up the nature of his activities.

(h) The Respondent's attempt to cover up his activities evidences the knowing and willful nature of his activities with respect to filing claims for Medicaid reimbursement and is a substantial aggravating factor which justice requires be considered. Tr 1/59-160; I.G. Ex 88/63-64, 116-117; I.G. Ex 93D/42-43.

(i) The Respondent's claims for reimbursement demonstrate a pattern of Medicaid fraud.

(j) The Respondent has demonstrated a high degree of culpability.

(k) The Respondent's acts of filing fraudulent Medi-Cal claims after being indicted on 10 counts of filing false claims and grand theft is a substantial aggravating factor which justice requires be considered.

(l) The I.G. has established by clear and convincing evidence the existence of substantial aggravating circumstances which justify imposition of penalties in the amount of $81,000

and assessments in the amount of $1,508.19 (minus 34.(c) below) and suspension from program participation for a period of five years.

32. The Respondent has met the burden of proving that there is one mitigating factor. The Respondent provided services to Kathleen Marsh on November 20, 1979 instead of November 29, 1979.

33. The same factors that are considered in determining penalties and assessments are to be considered in determining the length of a suspension. 45 C.F.R. §101.107.

34. The amount of the proposed penalty, assessment, and suspension is reasonable and appropriate under the circumstances of this case:

(a) The maximum penalty in this case is $162,000.00 ($2,000 x 82 false claims, minus $2,000.00 for one claim where I found mitigating circumstances).

(b) The I.G. has proved sufficient damages to warrant the proposed assessment against the Respondent less the amount indicated below in (c). Damages are twice the amount of the federal share paid to the Respondent, plus costs of this action with regard to the 82 false claims, minus one claim where I found mitigating circumstances. See United States v. Woodbury, 359 F.2d 370 (9th Cir. 1966).

(c) The amount paid to the Respondent with regard to the 85 claims in issue was $3,016.38; one half represents the federal share, i.e., $1,508.19. The maximum assessment is $2,776.38 (2 x $1,508.19) (minus $60 for each of three claims found not to be false and one claim where I found mitigating circumstances).

(d) The penalties and assessments imposed are not greater than the amount which could have been imposed under the False Claims Act.

(e) The Regulations require, and the I.G. has proven by clear and convincing evidence, that the Respondent presented or caused to be presented 82 false claims in issue and that this could have rendered the Respondent liable under the False Claims Act, for payment of an assessment and penalty more than that imposed. See Regulations §101.114(b)(2); Findings 13-18, supra; Discussion, infra.

35. Any part of the following Discussion and any part of this Decision and Order preceeding the Findings of Fact and Conclusions of Law which is or may be deemed a finding of fact or a conclusion of law is hereby incorporated herein as a finding of fact or conclusion of law.

DISCUSSION

The Respondent raised several procedural or jurisdictional arguments in the form of objections or motions during the prehearing process, at the hearing, and in his Post Trial Brief; these issues are discussed first because they are in the nature of a motion to dismiss, for judgment on the pleadings or a motion for special relief. The Respondent argues that the Act and Regulations cannot be applied to him in this case because the claims in issue were presented prior to the effective date of the Act, August 13, 1981. He argues that to apply the Act retroactively, rather than applying the predecessor statute, the False Claims Act, 31 U.S.C. §3729, violates the ex post facto (Article 1, §9, clause 3) and due process clauses of the United States Constitution. (RB 4 to 7.) 8/ 9/ The basis of the Respondent's ex post facto clause argument is that the Act and Regulations are "penal" in nature and that they are more "onerous" than the provisions of the False Claims Act, the law in effect at the time the alleged false claims were presented by the Respondent, thus placing him at a disadvantage, citing Weaver v. Graham, 450 U.S. 29, 29 (1981). (RB 4 to 6.) The basis of the Respondent's due process argument is that because the claims in issue were presented prior to the effective date of the Act, the institution of this case under the Act and Regulations, rather than under the False Claims Act, deprives the Respondent his right to a jury trial, the protections of the Federal Rules of Evidence, and the extensive discovery procedures guaranteed by the Federal Rules of Civil Procedure (RB 6 to 7.) 10/ In short, the Respondent believes that he has a right to have this case heard by an Article III Court, rather than administratively. Finally, the Respondent argues

8/ "RB" references are to the Respondent's brief. "RRB" refer to the Respondent's reply brief. "I.G.B" references are to the I.G.'s brief. "I.G.RB" references are to the I.G.'s reply brief.

9/ The predecessor law in effect prior to August 13, 1981, was and still is, the civil False Claims Act, 31 U.S.C. §231 et seq., (amended or reworded slightly on September 13, 1982 and recodified as §3729); the False Claims Act has been in effect since 1865. The criminal portion of the False Claims Act is found at 18 U.S.C. §287 et seq. All references in this Decision and Order are to the civil False Claims Act.

10/ Generally, the right to a jury trial is provided by the 6th Amendment to the Federal Constitution. See United States v. State of New Mexico, 642 F. 2d 397 (10th Cir. 1981).

that the Respondent's criminal conviction in State court and subsequent restitution order issued by that court acts to estop the I.G. from seeking civil money penalties and assessments here.

The I.G. argues that the ALJ has no authority to rule on constitutional issues, that the Act may be applied retroactively with regard to civil money penalties and assessments (so long as it is limited to the liability that the Respondent would have been subject to under the False Claims Act), that the Respondent may be suspended (even though the False Claims Act does not specifically provide for suspension), and that trying this case before an ALJ (administratively, rather than before an Article III Court) does not deprive the Respondent of any due process rights. (I.G. B 28 to 33; I.G. RB 1 to 11.) Finally, the I.G. argues that the State Court's judgment does not act as an estoppel or in any way preclude this federal administrative action.

I render no binding opinion on the constitutionality of the Act and Regulations because "the ALJ has no authority to decide on the validity of federal statutes or regulations." Regulations §101.115(c). Even if I had that authority, I believe that my interpretation of the Act and Regulations herein may resolve the issues raised by the Respondent without resort to deciding constitutional questions. Generally, courts will not pass on a constitutional question if there is some other ground upon which the case may be disposed of, such as a question of statutory construction. Ashwander v. TVA., 297 U.S. 288, 341 (1936), Justice Brandeis concurring. Tantamount to my authority under the Administrative Procedure Act (5 U.S.C. §551 et seq.), and the Act and Regulations, to hear and decide this case, I must make findings and conclusions and interpret the provisions of the Act and Regulations. Moreover, it is a cardinal principle of statutory construction that every attempt should be made to save, not destroy, the legislative product. In re United States, 563 F. 2d 637, 642 (4th Cir. 1977).

I. The Act And Regulations Provide For Civil Money Penalties And Assessments For False Or Improper Claims Which Were Presented Or Caused To Be Presented Prior To The Effective Date Of The Act

Section 1128A of the Act provides for civil money penalties and assessments. The effective date of the Act is August 13, 1981. The claims in issue in this case (I.G. Ex 2-86) were presented for payment prior to the effective date of the Act. It is clear that the Regulations, which implement the Act, apply to these claims for the following reasons.

The preamble to the Regulations states:

> The ex post facto clause of the United States Constitution, Art. I, section 9, cl. 3, does not bar the retrospective application of this statute to claims filed before the Act's effective date. It is well settled that the clause pertains only to criminal statutes that make punishable conduct that was not criminal at the time it was committed, that increase the amount of punishment for past conduct, or that alter the rules of evidence to make it easier to convict a criminal defendant. Calder v. Bull, 3 U.S. (3 Dall.) 386 (1878).

48 Fed. Reg. 38828 (August 26, 1983).

The preamble further states that, although section 1128A (§1320a-7a) of the Act does not expressly provide for retroactive treatment, "there is some indication in the legislative history that Congress intended it to so apply." Id.

Section 101.114(b) of the Regulations provides:

> (b) to the extent that a proposed penalty and assessment is based on claims presented before August 13, 1981, the Inspector General must prove by clear and convincing evidence that:
> (1) the Respondent presented or caused to be presented such claims as described in §101.102 and
> (2) presenting or causing to be presented such claims could have rendered Respondent liable under the provisions of the False Claims Act. 31 U.S.C. 3729 et seq. for payment of an amount not less than that proposed.

These implementing Regulations have the force and effect of law. So long as the Regulations are not inconsistent with the Act, for purposes of this Decision and Order, I need inquire no further. I conclude that the Regulations are not inconsistent with the Act because the Act is silent with regard to retroactivity, the Act's legislative history suggests that retroactive treatment be accorded and the Regulations provide certain guarantees (discussed infra) that protect respondents from overreaching.

Accordingly, the Act and Regulations provide for civil money penalties and assessments for false or improper claims which were presented prior to the effective date of the Act.

The only time limitation on these types of actions is found in section 101.132 of the Regulations, which provides that an action must be brought by the I.G. within five years from the date "on which the right of action accrued." (This is not in issue in this case.)

Moreover, I am satisfied that even if I had the authority to rule on the constitutionality of this retroactive application, there is no repugnance in this case because (1) the Act is not "penal" or "quasi-criminal" in nature (see United States v. Ward, 448 U.S. 242, 251 to 254 (1980) where a "civil penalty" was held not to be "quasi-criminal"); see also, United States v. Cooperative Grain and Supply Co., 476 F. 2d 47 (8th Cir. 1973), and (2) as will be discussed more fully infra, the Regulations guarantee that the liabilities cannot be more onerous than those imposed under the predecessor statute, the False Claims Act.

II. The Act And Regulations Avoid Potential Constitutional Conflicts By Guaranteeing That The Amount Of Civil Money Penalties And Assessments Be No Greater Than Those Which Could Have Been Imposed Under The False Claims Act (For Pre-August 13, 1981 Claims).

While the preamble to the Regulations states that the ex post facto clause of the United States Constitution does not bar the retrospective application of the Act and that the Act is not a criminal or penal statute, the body of the Regulations goes much further and guarantees that, even if the Act were deemed to be a penal statute, which it is not, the Act cannot generate penalties and assessments greater than those that could have been imposed under the predecessor statute, the False Claims Act. Section 101.114(b) of the Regulations provides this guarantee to any Respondent submitting claims prior to August 13, 1981 and makes the I.G.'s burden of proof the same as it would be if he were proceeding under the False Claims Act.

III. The Regulations Provide For A Suspension If Penalties Or Assessments Are Imposed Against A Respondent On The Basis Of Pre- August 13, 1981 Claims

On the one hand, one could argue, as the Respondent does, in effect, that a literal reading of the preamble to the Regulations provides that the sanctions which can be imposed under the Act are limited to those provided under the False Claims Act, which specifically mentions only penalties and assessments for damages and costs.

On the other hand, Section 1128(c) of the Act provides that the Secretary of DHHS may bar a Respondent from program participation if there is a final determination to impose a civil money penalty or an assessment and is silent with regard to retroactive application. 11/ What triggers the suspension in the Act is a final decision and order of civil liability imposed against a respondent. The Regulations specifically provide for retroactive application of the Act with regard to civil money penalties and assessments and accordingly, a suspension is triggered by an imposition of civil money penalties and assessments which are based on pre-August 13, 1981 claims.

The I.G. makes a convincing argument that the preamble is not inconsistent with the body of the Regulations, that a suspension is a remedial action, and that suspension in this case can be imposed on the basis of acts performed by the Respondent prior to the effective date of the Act (because the Respondent could have been subject to a suspension pursuant to a predecessor federal and a California statute). See Title 42 U.S.C. §1862(d)(1)(A). However, it is up to the Courts to decide whether this application required by the Regulations is violative of the Federal Constitution. I decide only that suspension is provided for under the Regulations because liability is found in this case and that the Regulations are consistent with the intent of the Act. Moreover, a suspension was triggered in this case, by reason of the Regulations, because the I.G. met his strict burden of proof regarding civil penalties and assessments under the False Claims Act standard; this in itself provided the Respondent, with some additional guarantees that the Respondent would not have if the alleged false or improper claims had been presented after August 13, 1981.

11/ 42 U.S.C. §1320 a-7(c) reads:

> Whenever the Secretary makes a final determination to impose a civil monetary penalty or assessment . . . . under section 1128A relating to a claim under Title XVIII [Medicare] or XIX [Medicaid], the Secretary -
>
> (1) may bar the person from participation in the program under title XVIII, and
>
> (2) ***may require [appropriate state agencies] to bar the person from participation in the program established [In spite of the fact that a quick literal reading of the preamble to the Regulations seems to require a strict False Claims Act standard with no suspension, under title XIX].

The fact that there has been a suspension provision on the books since 1972, lends credence to the I.G.'s conclusion. I believe that the suspension authority under the Act does not reflect a substantial expansion of pre-existing liability, since section 1862(d)(1)(A) of 42 U.S.C. has authorized suspensions from program participation for filing false claims for periods well before the effective date of the Act.

IV. Collateral Estoppel Has No Application In this Case

The doctrine of collateral estoppel precludes relitigating an issue in a future action between the same parties where there is a final judgment in an earlier action. While some of the claims in issue here are the same as those litigated in an earlier action, that doctrine simply has no hint of application here because there is no showing by the Respondent that the parties in this action are the same as the parties in the State criminal action cited by the Respondent, or no showing that the I.G. or the Federal Government had the requisite control over that State Court action to preclude the I.G. from litigating the claims in issue in this civil money penalties, assessments and suspension case. Montana v. United States, 440 U.S. 147 (1979) United States v. Laskey, 60 F. 2d 765, 768 (9th Cir. 1978), cert. den.; see also DAVIS, Administrative Law Treatise, 2d Ed. 1978, chapter 16, §16.10; 444 U.S. 979 (1979); Cf. United States v. Fields, 592 F. 2d 638 (2d Cir. 1978), cert. den.; 442 U.S. 917 (1979). See, e.g., 18 U.S.C. §3579-80 for restitution that would estop the federal government if "global settlement" was employed. Nor is the doctrine of equitable estoppel applicable here. See Schweiker v. Hansen, 450 U.S. 785 (1981); United States v. Bureau of Revenue, 531 P. 2d 212 (N.M. Ct pp. 1975). Moreover, two generally well-known principles of law are that (1) a conviction or acquittal of criminal charges does not preclude a civil action like the one here and (2) successive state and federal criminal prosecutions are not precluded.

V. The Act And Regulations Give The Parties Due Process Guaranteed By The United States Constitution

The Respondent argues that because his request to transfer this case to the United States District Court was denied, he is denied a jury trial, the protections of the Federal Rules of Evidence, and the discovery procedures guaranteed by the Federal Rules of Civil Procedure, resulting in a deprivation of substantive due process rights guaranteed by the Federal Constitution. Keeping in mind that the Respondent's due process arguments are enmeshed with his principal argument of illegal retroactivity of the Act and Regulations, he is really saying that he ought to have the opportunity to either defend the I.G.'s proposed civil money

penalties, assessments and suspension in federal court under the predecessor statute, the False Claims Act, or be accorded the same procedural rights here as he would be accorded in federal court. While I disagree, this argument should be discussed. As discussed above, I believe that the Act and Regulations are not violative of the ex post facto clause of the United States Constitution, and that the Act and Regulations apply retroactively. However, any due process argument raised by a party deserves consideration because "the right to be heard before being condemned to suffer grievous loss" is a basic principle of our law. Mathews v. Eldridge, 424 U.S. 319, 333 (1976), quoting Justice Frankfurter in Joint Anti - Fascist Refugee Comm. v. McGrath, 341 U.S. 123, 168 (1951).

The I.G. argues that the result of proceeding here under the Act and Regulations, instead of in a federal court under the False Claims Act, is merely a change in procedure and does not affect the substantive rights of the Respondent. In addition, the I.G. argues that since this is a civil action and not criminal or "quasi-criminal" in nature, the Respondent is not entitled to constitutional protections that would be accorded a criminal defendant. Again, being mindful that I have no authority to rule on "the validity of federal statutes or regulations," I may only construe the Act and Regulations in light of the above arguments.

While the Respondent had no right to a jury, and technical rules of evidence were not applicable during the hearing in this case, the Respondent had a right to a trial-type hearing before an ALJ under the Act and Regulations, a requirement that is fundamental to due process. See Regulations §§101.111 (right to a hearing), 101.113 (notice of hearing), 101.114 (burden of proof), 101.115 (right to a fair hearing to be conducted by an ALJ), 101.116 (rights of parties), 101.117 (discovery rights), 101.118 (evidence and witnesses), 101.120 (no ex parte contacts) 101.121 (separation of functions), 101.122 (official transcript), 101.123 (briefs and proposed findings of fact and conclusions of law) 101.124 (record), 101.125 (decision and order), 101.126 (judicial review), and 101.132 (limitations); Act §1128A; Londoner v. Denver, 210 U.S. 373, 386 (1908); DAVIS, Administrative Law Treatise, 2d Ed. 1978, chapters 12, 13. The Respondent had notice of the I.G.'s proposals, a fair hearing, the opportunity for discovery and the opportunity to cross-examine witnesses. See Mathews v. Eldridge, supra, at p. 335 (1976); Greene v. McElroy, 360 U.S. 474 (1959).

Even so, the Respondent argues that if this action were in a federal court, the Respondent would have had the opportunity to depose the witnesses called by the I.G., that hearsay statements would not have been admitted into evidence, and that he could

have required that the board and care patients submit to psychiatric examination. First, the Respondent is correct in arguing that the Regulations do not allow for depositions, Regulations §101.117. However, the Respondent already had the opportunity to, and in fact did, cross-examine all of the witnesses called by the I.G. in this case during the course of the State criminal proceedings or at the hearing in this case. Moreover, under the Regulations, the Respondent had the right to cross-examine all witnesses called by the I.G. well beyond the normal scope of cross-examination because §101.118(d) provides:

> (d) a witness may be cross-examined on any matter relevant to the proceeding without regard to the scope of his or her direct examination.

Furthermore, the Respondent was given the opportunity to interview all witnesses called by the I.G. during the prehearing process in this action; the Record discloses no attempt by the Respondent to do so. With regard to the Respondent's argument about lack of depositions, and the admission of objectionable hearsay statements into evidence (the admission of prior sworn statements of patients in lieu of testimony), the record discloses no attempt made by the Respondent to subpoena these witnesses and cross-examine them at the hearing (even after he was given that opportunity by me). The dispositive case on this issue is Richardson v. Perales, 402 U.S. 389 (1971) which holds that where the Respondent fails to attempt to confront a witness, the witness statement may be substantial evidence even though it is hearsay. Finally, I do not believe that there is a Federal Rule of Evidence that permits the psychiatric examination of a group of witnesses (1) without more of an effort by the Respondent to show the efficacy of such an exercise and (2) in light of the fact that the Respondent had the opportunity to test the competency and credibility of these witnesses at the hearing and made no discernible effort to do so. It should be noted that, although hearsay is admissible in this proceeding, it must be credible and reliable and used in a fair manner to have any probative value. See 5 U.S.C. §556(d); Catholic Medical Center v. NLRB 1589 F. 2d 1166 (2d Cir. 1978); DAVIS, supra at §§16.4 and 16.5.

Despite my ruling, the Respondent has the right to have his constitutional arguments decided by the United States Court of Appeals for the Ninth Circuit, if he appeals. Thus, assuming the Respondent appeals, it is up to the Ninth Circuit to determine if the Respondent is seriously disadvantaged in violation of the United States Constitution or whether the I.G. is correct in arguing

that the retroactive treatment in this case is merely a harmless change in procedure and is not violative of due process because this is a civil proceeding and not "quasi-criminal" in nature. Ward, supra 12/

VI. The I.G. Presented Clear And Convincing Evidence That The Respondent Knew That 82 of The 85 Claims In Issue Which Were Presented For 45 to 50 Minutes Of Individual Psychotherapy Services Were Not Provided As Claimed, In Violation Of The Act And Regulations

The I.G. argues that he has shown by clear and convincing evidence that the Respondent knowingly presented 85 Medicaid (Medi-Cal) false claims from November 28, 1979 to February 29, 1980 for services that were not provided as claimed, that the Respondent was paid $3,016.38 for those services, that the Respondent was not entitled to any payment for the claims submitted, and that the claims at issue were a small part of a continuing scheme by the Respondent from 1973 to 1980 to obtain Medicaid (Medi-Cal) reimbursement in violation of the Act and Regulations. The I.G. argues that he need not show intent to defraud, but only that the Respondent knowingly filed the claims in issue, that there exist substantial aggravating factors, and that the amount of penalties and assessments proposed are less than what could have been imposed under the False Claims Act.

In addition to the objections and motions made by the Respondent which are outlined above, the Respondent argues that the evidence presented by the I.G. was insufficient to meet the burden of proof required, that the Act and Regulations do not apply to Medicaid (Medi-Cal) claims, that the amount of penalties and assessments proposed here is greater than the Respondent would have been liable for under the False Claims Act, that the I.G. failed to follow its internal formula in formulating the amount of penalties and assessments, and that there are mitigating circumstances present in this case. The Respondent also argued that certain witnesses presented by the I.G. were not credible and that his witnesses are more reliable and credible.

12/ It should be noted that the reason the Supreme Court held that the Self-Incrimination Clause of the Fifth Amendment did not apply in Ward was because the federal statute specifically provided that any information obtained "shall not be used against any such person in any criminal case." Here, there is no such protection. Thus, I agree with the Respondent that this privilege is applicable here if a person could show that the information requested would prejudice them in respect to later or current criminal proceedings; it is not, however, a blanket privilege and must be determined on a question by question basis. There was no attempt made by the Respondent to testify on his own behalf, so this privilege, although raised by the Respondent's counsel, was never actually invoked by the Respondent.

I conclude that the I.G. presented clear and convincing evidence establishing that the Respondent knew that each of 82 out of the 85 claims in issue (I.G. Ex 2 to 86, except for 7, 77 and 83) which were presented for 45 to 50 minutes of individual psychotherapy services were not provided as claimed, in violation of the Act and Regulations, and that the Respondent intended to defraud the Medicaid system by submitting false claims in a scheme to obtain monies to which he knew he was not entitled. On each of the 82 false claims, the Respondent's provider number is indicated, each patient is listed as suffering from schizophrenia or mental retardation, or both, and the Respondent signed the claim certifying that he provided 45 to 50 minutes of individual psychotherapy. Tr 1/57. Most of the patients listed in the 82 claims are residents of one of four board and care homes operated by Freda Farris. During the period November 28, 1979 to February 29, 1980, the period in which the Respondent claims to have rendered individual psychotherapy services to those patients identified in the 82 false claims, the Respondent was under surviellance by investigators of the California Department of Justice, Medi-Cal Fraud Unit. This investigation led to a criminal conviction of the Respondent that he is appealing. Even without the fact of this conviction, there is sufficient clear and convincing evidence in this record to lead me to conclude that the Respondent knowingly submitted 82 false claims with the intent to defraud the Medicaid system and obtain monies that he knew he was not entitled to.

A. Requirements And Standards For Filing Medi-Cal Claims

The Medicaid program is a system under which the Federal Government provides financial assistance to States to aid them in furnishing health care to needy persons when they submit a "State Plan" to the Secretary of DHHS that fulfills federal requirements. 42 U.S.C. §1396a. The California Department of Health Services (CDHS) administers the Medicaid program for California, which is known as the "Medi-Cal" program. The CDHS has promulgated strict requirements for the filing of claims for Medi-Cal reimbursement. See Title 22, §51502 C.A.C. Blue Shield of California (BSC) is the fiscal intermediary for the Medi-Cal program. Tr 1/51. Each claim must provide the name, address, Medi-Cal provider number, and signature of the provider certifying that the information on the billing form is correct, a coded description of the services provided, the charge for the services provided, and contain a proof of eligibility (POE) label affixed to the claim form; POE labels are issued to all Medi-Cal beneficiaries each month. Tr 1/55 to 60; I.G. Ex 94B/75, 103. The coded description of services provided to a beneficiary is determined by referring to the California Relative Value Studies (CRVS), published by the California Medical Association. I.G. Ex 94B/7, 98. The procedure numbers for services provided to Medi-Cal beneficiaries are derived from the

1974 edition of the CRVS and payment is determined from the relative values in the 1969 CRVS. Tr 1/71-72; I.G. Ex 94B/8; I.G. Ex 93A/69. Individual psychotherapy is billed in 15, 25 and 45 to 50 minute increments; group psychotherapy is billed in 45 to 50 minute or 90 minute increments for each of the members, and each claim must indicate where the service is provided (i.e., office, hospital, other facility or home). I.G. Ex 98/17. The following are the correct CVRS codes for individual psychotherapy:

45 to 50 minutes in office	= 90803
45 to 50 minutes in residence	= 90805
25 minutes in residence	= 90808
15 minutes in residence	= 90813
less than 15 minutes in residence	= 90440

Tr 1/72, 73, 2/13; I.G. Ex 98/15, 17, 94B/12, 14.

The following are correct CVRS codes for billing for group psychotherapy:

45 to 50 minutes with a maximum 8 patients in office = 90815
45 to 50 minutes with a maximum 8 patients outside office = 90816
45 to 50 minutes with a maximum of 16 patients in office = 90821
45 to 50 minutes with a maximum of 16 patients outside office = 90822

Tr 1/75 to 76; I.G. Ex 98/17.

Group therapy cannot ever be billed under the individual therapy codes; individual codes are limited to one-on-one therapy where privacy is required. Tr 1/77; I.G. Ex 94B/10, 11. Psychotherapy sessions must be billed for the exact amount of time given in each session and cannot be accumulated over a number of small sessions. Tr 1/77, 78, 2/14 to 15; I.G. Ex 94B/11 to 13, 38 to 39; 93A/76, 96. Individual and group psychotherapy can be billed to Medi-Cal only if there is face-to-face interaction between the psychotherapist and patient; no other activities can be billed for. Tr 1/78, 80, 2/9 to 10; I.G. Ex 94B/27, 39, 40, 94A/76, 99. Medi-Cal issued bulletins, such as bulletin 96, dated January 1979, which clarified the fact that only direct psychotherapy is covered and that other activities, such as consultation with board and care operators, cannot be billed to Medi-Cal. A psychiatrist is expected to keep a record of a patient's visit, medication prescribed and any significant observations. Tr 2/13 to 14; 42 C.F.R. §431.107; title 22 C.A.C. §51476.

B. The Respondent's Practice Of Psychiatry For The Period In Issue

Most of the Respondent's practice of psychiatry in Santa Clara County, California, was devoted to Medi-Cal patients from 1976 up to the years in issue here. The Respondent's patients were largely developmentally disabled persons living in board and care homes which provide care and supervision to such persons in a community. Tr 1/97, 99. Most of the 85 claims in issue here relate to four board and care homes operated by Freda Farris located at:

1. 119 S. 13th Street, San Jose, California.
2. 177 S. 12th Street, San Jose, California.
3. 1206 Main Street, Santa Clara, California.
4. 1264 Lincoln Street, Santa Clara, California.

C. Complaints And Investigations Regarding The Respondent

Prior to 1979, three complaints were made against the Respondent, and investigated, resulting in no formal charges; the first involved an alleged conversation that was overheard; the second alleged that the Respondent might be billing for longer sessions than actually conducted; the third involved an accusation by a board and care home operator that the Respondent took two Medi-Cal POE labels from a resident patient when the Respondent allegedly saw the patient only 1 time and only for 5 to 10 minutes. I.G. Ex 88/5, 6. These complaints resulted in no action being taken against the Respondent.

In 1979, Setsuko Furuike, a psychiatric social worker employed by the California Department of Developmental Services, filed a complaint against the Respondent based on two incidents, which resulted in an investigation by the California Department of Justice. Tr 1/93 to 97, 195 to 196; I.G. Ex 88/11. As a result, John Shea, an investigator with the California Department of Justice Medi-Cal Fraud Unit, placed the Respondent under surveillance from August 22, 1979 to February 29, 1980 (Tr 1/99 to 111) and a criminal complaint (ten felony counts) was filed against the Respondent, based on Shea's report. After the criminal complaint was filed, and before the trial, another criminal complaint was filed against the Respondent on the basis of a second investigation initiated by Phil Yee, Special Agent, California Department of Justice, Bureau of Investigations, resulting in a second criminal complaint (four felony counts). TR 1/118 to 119, 2/19, 29 to 38; I.G. Ex 89, 93A-F, 96. Based on this second complaint, the Respondent was convicted of four counts of presenting false Medi-Cal claims, in violation of California Welfare and Institutions Code §14107, on October 20, 1983. Stip. 9; Tr 2/33; I.G. Ex 95. That case is on appeal.

Besides the surveillance, Shea conducted numerous interviews with board and care employees, residents, and owners. With the cooperation of some of these people and Ms. Furuike, the surveillance and with the interview of the Respondent by Shea, Shea learned about the Respondent's practices of filing false Medi-Cal claims. Tr 1/118, 119; I.G. Ex 87, 88/101 to 104.

Based on the two criminal complaints, and the felony conviction, the California Board of Medical Quality Assurance initiated disciplinary proceedings against the Respondent. I.G. Ex 95, 105, 106/2. The Board charged that the Respondent submitted 132 claims for individual psychotherapy in the patient's home or in the office when he either conducted brief visits at custodial care facilities or provided no therapy at all, and he signed and submitted the claims knowing them to be false. I.G. Ex 105/2, 3, 106/2. The Respondent admitted all charges and was given a five year probationary period. I.G. Ex 107/2, 3.

D. Liability Under the Act And Regulations

The I.G. proved by clear and convincing evidence that the Respondent knowingly submitted 82 out of 85 Medi-Cal claims for 45 to 50 minute sessions of individual psychotherapy in the patient's home or in the Respondent's office, when in fact the Respondent either conducted brief visits or group therapy at board and care homes or conducted no therapy at all. The Act and Regulations require that the I.G. prove by clear and convincing evidence that the Respondent presented or caused to be presented false claims that could have rendered the Respondent liable under the False Claims Act for payment of an amount "not less than that imposed" by the I.G. 45 C.F.R. §101.114(b). The civil False Claims Act provides for a civil penalty of $2,000 for each false claim and an amount equal to two times the amount of damages the Government sustains.

Here, the I.G. has more than met his burden of proof and has demonstrated that the Act and Regulations as well as the False Claims Act are applicable to false claims submitted to State Medicaid programs. See U.S. v. Jacobson, 467 F. Supp. 507 (S.D. N.Y. 1979); U.S. ex rel. Davis v. Long's Drugs Inc. 411 F. Supp. 1144 (S.D. Cal. 1976). As one court noted, "[a]ny fraud-based claim in the Medicaid program . . . results in an impairment of the federal treasury because the Government expends money it would

not expend 'but for' the fraud." U.S. ex rel. Fahner v. Alaska, 591 F. Supp. 794, 798 (N.D. Ill. 1984). Accordingly, civil penalties may be imposed under the Act for false claims submitted to a state Medicaid agency. Id.; See also U.S. ex rel. Marcus v. Hess, 317 U.S. 537, 552 (1943).

Thus, under the False Claims Act, anyone determined to have filed false or fraudulent claims is subject to a penalty of $2,000 per claim and double the damages incurred by the Government. See United States v. Bornstein, 423 U.S. 303 (1976); United States v. Ehrlich, 643 F. 2d 634 (9th Cir. 1981). Similarly, those who have submitted false claims or requests for payment under the Medicare, Medicaid, or Maternal and Child Health Services block Grant Programs, prior to August 13, 1981, are subject to the same liability under the Act and Regulations. 48 Fed. Reg. 38828, 38829 (August 26, 1983). It should be noted that the I.G. argues that the Act and Regulations apply to the "negligent" as well as the "knowing" presentation of false claims here because the False Claims Act applies to the "negligent" as well as the intentional submission of a false claim. (See I.G. B 29.) 13/ There is some question as to whether the Ninth Circuit would agree. See United States v. Mead, 4626 F. 2d 118 (9th Cir. 1970). 14/

13/ Actual knowledge of the falsity of a claim is not required to sustain a criminal conviction under 18 U.S.C. §1001 (false statements) or 18 U.S.C. §237 (false claims). The conviction will be sustained on showing that the defendant had a "reckless disregard" for truthfulness and a "conscious purpose" to avoid learning the truth. United States v. Evans, 559 F. 2d 244 (5th Cir. 1977); United States v. Restrepo-Granda, 575 F. 2d 524 (5th Cir. 1978) (willful ignorance of importing a controlled substance); United States v. Cook, 586 F. 2d 572 (5th cir. 1978).

14/ In reading United States v. Cooperative Grain and Supply Co., supra, an Eighth Circuit case, the Court held that proving extreme negligence (i.e., reckless disregard for the truth) is tantamount to providing intent and the Court implied that the degree of negligence required to permit the government to recover under the False Claims Act is the same as that which a plaintiff must prove in a common law action for negligent misrepresentation. Also, the standard of proof necessary to prevail on the basis of a civil fraudulent claim is "clear and convincing evidence." Hageny v. United States 570 F. 2d 924, 933-934 (Ct. Cl. 1978).

The I.G. argues that, at most, the False Claims Act requires only that the Respondent knowingly present a false claim to the Government in order to violate the statute, citing United States v. Hughes, 585 F. 2d 284 (8th Cir. 1973); United States v. Krietemeyer, 506 F. Supp. 289 (S.D. Ill. 1980); United States ex rel. Fahner v. Alaska, 591 F. Supp. 794 (N.D. Ill. 1984); Fleming v. United States, 336 F. 2d 475, 479 (10th Cir. 1964) and United States v. Toepleman, 141 F. Supp. 677, 683 (E.D. N.C. 1956). On the other hand, the Ninth Circuit has held that in order to prevail, the Government must demonstrate that the Respondent had an actual or specific intent to defraud. United States v. Mead, supra. The I.G. argues that the ALJ may not be bound by the Ninth Circuit's holding in Mead, and that later cases dilute the holding in Mead, citing United States v. Milton, 602 F. 2d 231 (9th Cir. 1979); United States v. Kennedy, 431 F. Supp. 877, 878 (C.D. Cal. 1977). However, the question of whether the I.G. need prove intent as suggested by Mead is academic because I find that the I.G. has proven that the Respondent not only knowingly submitted 82 false claims but also intended to defraud. See Discussion, infra.

E. The False Claims Presented By The Respondent

It is clear that the Respondent submitted the 85 claims in issue (I.G. Ex 2 to 86), that each claim contains the Respondent's provider number, and his signature. Steven Lack, an investigator for the I.G., testified at the hearing that he conducted an audit and determined that all 85 claims had been submitted to Blue-Shield of California (BSC) and that the Respondent had been paid on each of the claims. Tr 1/64, 68, 2/45; I.G. Ex 100, 102. On each claim, the Respondent certified that he had provided 45 to 50 minutes of individual psychotherapy.

I conclude that the I.G. proved by clear and convincing evidence that the Respondent knew that he provided less than 45 to 50 minutes of individual psychotherapy for the patients named in the 82 false claims, that the Respondent was familiar with the CVRS codes, knew that he would obtain only a fraction of the money if he submitted claims for the correct amount of time provided to each of the patients in question, and deliberately chose to obtain more money than he knew he was entitled to under Medi-Cal regulations. The Respondent had to be well aware that he was filing false claims because he had already been investigated by the State more than once prior to 1979 and when interviewed by State investigators, admitted that he chose to misidentify the place, dates and length of services provided on claims submitted to Medi-Cal. I.G. Ex 87/6 to 15, 19, 20, 21, 23, 25, 28, 30.

It should be noted at the outset that all but four of the 85 claims represented that the Respondent performed 45 to 50 minutes of individual psychotherapy services at the patient's residence. (See I.G. Ex 7 (2 sessions 2/5/80 and 2/20/80), 53, (1/2/80), 77 (2/19/80), 83 (2/20/80). The other four alleged that he performed those services in his office.

The following is a summary of each of the false claims presented by the Respondent and the clear and convincing evidence proving that the claims are false:

1. Five False Claims = I.G. Ex 2 to 6; November 14, 1979, Visit to 119 S. 13th Street, San Jose (Residents attending were also from the other Freda Farris facility at 177 S. 12th Street, San Jose): 15/

The Respondent visited this facility only one time in November 1979 (i.e., November 14, 1979) and only for 46 minutes. He submitted five claims for 45-50 minutes of individual psychotherapy services allegedly performed at the residents' facility (CVRS Code 90805). The proof is clear and convincing that the Respondent did not perform individual psychotherapy for any of these residents in November 1979, except that he did see Kathleen Marsh (I.G. Ex 3) on November 20, 1979 in his office; accordingly, the I.G. demonstrated that all these claims were false claims (including Kathleen Marsh's, because Respondent used the wrong CVRS Code, i.e., indicated that the services were performed at her residence instead of his office, and used the wrong date November 29, 1979 instead of November 20, 1979). However, because this could have been a harmless clerical error, the I.G. did not prove intent to defraud, and the Respondent did perform the services for Kathleen Marsh, this will be considered as a mitigating factor and the penalty and assessment will be removed. I.G. Ex 88/ 15 to 17, 45, 93D/46, 81, 82, 84.

2. Four False Claims = I.G. Ex 8 to 11; November 1979 visit to 1206 Main Street, Santa Clara: 16/

The Respondent visited this facility only one time in November 1979 (i.e., November 14, 1979) and only for 26 minutes. He submitted four claims for 45 to 50 minutes of individual psychotherapy services

15/ The I.G. has clearly established that it was the practice of the Respondent to have residents of nearby facilities gather together at one facility and conduct only one meeting per month at one of the two nearby facilities.

16/ Id.

allegedly performed at the resident's facility (CVRS Code 90805). The proof is clear and convincing that the Respondent did not perform the services as claimed and that these residents of the Freda Farris facilities did not receive 45 to 50 minutes of individual psychotherapy services from the Respondent in November of 1979. I.G. Ex 88/15, 17, 18; Tr 1/155.

3. Eleven False Claims = I.G. Ex 12 to 22; December 13, 1979 visit to 1206 Main Street, Santa Clara: 17/

The Respondent visited this facility only one time during the month of December 1979 for only 36 minutes (on December 13, 1979) and claimed to have performed eleven 45 to 50 minute sessions of individual psychotherapy at this facility or at the other nearby Santa Clara facility; he did not visit the other nearby facility at all in December, as residents from that facility attended the December 13, 1979 group meeting. I.G. Ex 88/20, 21, 28, 31, 92; Tr 1/53 to 154. All claims were for Freda Farris residents.

4. Fourteen False Claims = I.G. Ex 26 to 39; December 13, 1979 visit to 177 S. 12th Sreet, San Jose: 18/

The Respondent visited this facility only one time during the month of December 1979 for only 13 minutes (on December 31, 1979) and claimed to have performed fourteen 45 to 50 minute individual psychotherapy sessions at this facility or at the other nearby San Jose facility; he did not visit the nearby San Jose facility at all in December, as residents from that facility attended the December 13, 1979 group meeting. I.G. Ex 88/23, 49 to 51; 36; 93C/120, 124. All fourteen claims were for Freda Farris residents.

5. Eleven False Claims = I.G. Ex 42 to 53; January 9, 1980 visit to 177 S. 12th Street, San Jose: 19/

The Respondent visited this facility once during the month of January 1980 for only 36 minutes (on January 9, 1980) and claimed to have performed more than eleven 45 to 50 minute sessions of individual psychotherapy at this facility or at the other nearby San Jose facility; he did not visit the other facility at all in January as residents from that facility attended the January 9, 1980 group meeting. I.G. Ex 88/29, 30, 49 to 51; I.G. Ex 91; I.G. Ex 93C/113 to 124. All claims were for Freda Farris residents.

17/ Id.

18/ Id.

19/ Id.

6. Twelve False Claims = I.G. Ex 55 to 65, 86; January 9, 1980 visit to 1206 S. Main Street, San Jose: 20/

The Respondent visited this facility once during the month of January 1980 for only 42 minutes (on January 9, 1980) and claimed to have performed more than twelve 45 to 50 minute sessions of individual psychotherapy at this facility or at the other nearby San Jose facility; he did not visit the other facility at all in January as residents from that facility attended the January 9, 1980 group meeting. I.G. Ex 88/29, 31, 32. All twelve of these claims were for Freda Farris residents.

7. Twenty-five False Claims (of 28 claims) = I.G. Ex 7, 23 to 25, 40, 41, 53, 54, 66 to 85, claims submitted where there were no visits

Of the 28 claims listed above, four claims are for individual psychotherapy services performed in the Respondent's office (I.G. Ex 7, 53, 77, 83). While the I.G. proved by clear and convincing evidence that the Respondent did not visit any of the board and care homes including the four Farris board and care homes, as claimed on January 28, 1980, February 19, 1980 (I.G. Ex 75, 76, 78 to 80), February 20, 1980 (I.G. Ex 81, 82, 84, 85), February 21, 1980 (I.G. Ex 23 to 25, 40, 41, 67), or on February 29, 1980 (I.G. Ex 54, 66,) (i.e., proved that the Respondent could not possibly have rendered individual therapy at the resident's homes on those dates; I.G. Ex 88/ 40, 41, 62), the Respondent did spend 3 hours in his office on February 20, 1980 and I.G. Ex 7 and 83 each list one 45 to 50 minute session of individual psychotherapy in the Respondent's office on February 20, 1980. In addition, I.G. Ex 77 is a claim for individual therapy on February 19, 1980 for services provided at the Respondent's office and there is sufficient doubt as to whether the Respondent could have rendered this service in his office on that date.

I.G. Ex 53 is for individual psychotherapy rendered on January 2, 1980 for Ellen Alexion, a resident of one of the Freda Farris board and care homes (119 S. 12th Street) and I find that there is clear and convincing evidence that the Respondent did not render this service. See I.G. Ex 88. Also, I.G. Ex 7 lists one individual session for February 5, 1980, a date when the Respondent was out of town. See finding 16. With regard to all the other claims listed in the paragraph immediately above, the Respondent was under surviellance and did not perform the individual psychotherapy claimed in each of these claims at all because he never visited the board and care homes as claimed. I.G. Ex 88/33 to 40, 41, 62.

20/ Id.

F. The Intent to Defraud

Medi-Cal only reimburses for the time spent in face-to-face interaction between the psychiatrist and patient. Time spent consulting with the board and care home operator, processing licensing forms, dealing with social service agencies or other related functions cannot be billed to the Medi-Cal program. Dr. Reynaud specifically acknowledged this program restriction and yet billed Medi-Cal for these services.

After describing the variety of functions he performed as a consultant to the board and care homes in San Jose and Santa Clara, Dr. Reynaud explained, when interviewed by John Shea and Hector Comacho: "[B]ut there is no way that you can bill specifically for this. And I don't, I put it into the patient's care and bill each individual patient for this." I.G. Ex 87/7, 25. Also, the I.G. repeatedly requested that Dr. Reynaud produce documentation that would demonstrate when and where he saw the Medi-Cal patients. 21/ The Respondent objected to that request and alleged that he could not find any appointment books. In addition to the credible testimony and thorough report of John Shea's, the materials and testimony submitted by the board and care managers of the four Farris homes, the beneficiaries themselves deny receiving monthly therapy at the Respondent's office. I.G. Ex 88 at 119; I.G. Ex 94A at 56, 65, 71, 82, 92.

As to the argument that the Respondent mistakenly put the code for seeing the patients in their home, instead of at his office, the board and care managers, the report of investigation and statements of the patients prove this not to be true. For example, Joyce Webster (I.G. Ex 5, 35, 50) and Kathleen Marsh (I.G. Ex 3) both state they saw the doctor in his office only once. Id.; I.G. Ex 93E at 34. Similarly, Richard Wright (I.G. Ex 8, 86), Sandor Gardony (I.G. Ex 13, 56, 24) and Cornelius Adair (I.G. Ex 14, 55, 68), all residents of 1206 Main Street, say they had never been to Reynaud's office and did not know where it was located. Id. at 124; I.G. Ex 93E at 25; 94A at 56, 65-66, 71, 82, 92. Residents of 177 South 12th Street, including Ray White (I.G. Ex 26, 42), Tim Fenton and Brian Gray (I.G. Ex 2, 30, 45, 79), state that they had never been to Reynaud's office. I.G. Ex 88 at 120. Paul Terrell (I.G. Ex 61) said he went to the office once to get some papers signed. Residents of 119 South 13th Street, including Joan Altknecht (I.G. Ex 28), Deanna Wescott, Connie Sepulveda (I.G. Ex 4, 31, 46), and Ellen Alexion (I.G. Ex 38, 53), deny ever seeing Dr. Reynaud in his office. Id. at 121.

21/ See Inspector General's Discovery Motion, dated May 8, 1985; supplement to April 23, 1985 Revised Order, dated May 24, 1985; Inspector General's Motion to Compel Discovery, dated June 7, 1985; Request to Produce a Witness for Examination, dated June 7, 1985; Tr. 1/23. See Respondent's Objection to Notice to Appear and Produce Documents, dated June 17, 1985; Prehearing Order, dated June 13, 1985.

Moreover, Dr. Reynaud admits that he saw his Medi-Cal patients for less than the time claimed. While he represented on each claim that he had rendered 45 to 50 minutes of individual psychotherapy, the Respondent knew that he was seeing the patients for far less time and some of the time in groups only. When asked if he saw each patient in the board and care home for 45 minutes, Dr. Reynaud replied "Ok, yes pretty close. Sometimes it's 30 minutes or, but yeah." I.G. Ex 87 at 8. The Respondent confessed, "I might see this person 30 minutes one mon [sic], a month. Ok, I billed for 50 minutes, ah yeah. Now ok, sue me." Id. at 25. The justification the Respondent offers for his billing practices is that he is billing for the "total service" to the patient. Id. at 15.

According to the Respondent, he considered the 50 minutes of individual therapy to include consultation with the board and care home manager, dealing with social service agencies, and reviewing medication orders. Id. at 7. In addition, the Respondent claims to have accumulated brief visits with the patient over the month. Id. at 19, 8. The Respondent stated that he did not bill for the 15 or 25 minute sessions because ". . . I can't, I'm not set up for that. So I'll lump it." Id. at 20. The Respondent could submit a claim for 15 minutes of psychotherapy as easily as a claim for 50 minutes. In fact, he submitted one such claim for Agripena Vega. I.G. Ex 89 at 7. He elected not to do so in order to maximize his Medi-Cal payments. As Dr. Ryan observed, billing for a brief visit involves considerably less reimbursement than a claim for 50 minutes of individual therapy. Tr 2/13.

The evidence produced during the State's investigation of the Respondent clearly proves that Dr. Reynaud knew he was filing false Medi-Cal claims. John Shea's surveillance of Dr. Reynaud revealed that he would never spend more than one hour per month at each of Freda Farris' board and care homes. Interviews with other board and care home operators confirm that the Respondent only visited their facilities once each month for no more than one or two hours. I.G. Ex 88 at 49-51, 53, 55-63, 71, 73-74, 117-118. The Respondent admitted that these monthly visits were for the benefit of the board and care home in his role as a medical consultant. I.G. Ex 87 at 5-7, 11. During his monthly visits, the Respondent would collect the residents' Medi-Cal stickers for the month. But, the Respondent stated: "that does not mean that is the treatment session, it merely makes it convenient for me to get that Medi-Cal sticker at that time because if the patient comes here, for instance, you see, no way are they going to give them that sticker." Id at 11. The I.G. proved, by clear and convincing evidence, that these monthly visits to the homes were the only time the patients whose claims are the subject of this action even

had an opportunity to meet with the Respondent, except for the three claims where the I.G. failed to prove that the Respondent did not supply the services in his office on February 5, February 19 and February 20, 1980. Ms. Warr, manager of two of the Farris homes over the last ten years (Tr 1/148), explained that she made all medical appointments for her residents. I.G. Ex 93D at 16; Tr 1/151, 167. All appointments were recorded on a monthly calendar by Ms. Warr. Ms. Warr testified that she could not recall a resident ever telling her he was going to Dr. Reynaud's office without an appointment. Tr 1/155. In fact, she stated that only two residents, Karen Post and Carolyn Finch, had ever seen the Respondent in his office, and they saw him a total of four times. Tr 1/163. For the months of November and December 1979, no appointments for Dr. Reynaud were recorded. Tr 155; I.G. Ex 92.

Helen Barlow, manager of the Farris home at 13th Street, also testified during the first criminal proceeding against the Respondent about his treatment of patients in that home. Ms. Barlow confirms that the Respondent came to the facility only once a month (I.G. Ex 93D/82) and spent fifteen to thirty minutes with the group. Id. at 85. Like her counterpart, Ms. Warr, she made all medical appointments for her residents and recalls making only one appointment for an office visit to Dr. Reynaud. Id. at 85. As in the other Farris homes, residents at the 13th Street facility were not permitted to make their own medical appointments and were required to tell the manager if they were going to see a doctor. No resident ever notified Ms. Barlow of a visit to the Respondent's office. Id. at 86. The same testimony was elicited from Augusta Kennedy, Betty Mingus and Ollie Juarez, also managers of Farris board and care homes during the relevant time. I.G. Ex 88 at 49-51, 69-72; I.G. Ex 93D at 116-119, 137-139. According to all three managers, Dr. Reynaud's visits to the facilities occurred once a month (I.G. Ex 88 at 50, 71; I.G. Ex 93D at 121, 139), usually lasted less than one hour (I.G. Ex 88 at 51; I.G. Ex 93D at 122, 140) and consisted of a group meeting (I.G. Ex 88 at 50-51, 71; I.G. Ex 93D at 121, 140). Residents never saw Dr. Reynaud at his office without an appointment made by the manager (I.G. Ex 88 at 51; I.G. Ex 93D at 123, 141) and none of the managers could ever recall making an appointment for Dr. Reynaud. I.G. Ex 88 at 51, 71; I.G. Ex 93D at 123, 134, 142. Like the other managers, Ms. Juarez reported seeing Dr. Reynaud take Medi-Cal stickers from a card of a resident who had not attended the monthly group session. I.G. Ex 88 at 74, 107; I.G. Ex 93D at 141. Furthermore, Shea corroborated the manager's testimony by reviewing the appointment books used to record medical appointments for the residents. Ms. Warr's appointment book contained only one appointment with the Respondent during the eighteen-month period of January 1979 through July 7, 1980. This one appointment was for Carolyn Finch on October 13, 1979.

I.G. Ex 88 at 67. Similarly, Ms. Barlow's appointment books showed only two appointments with the Respondent ever made on behalf of individual residents between January 1979 to April 16, 1980. Id. at 46.

Moreover, the Respondent failed to appear at the hearing by his own choice. Because this is a civil proceeding and not "quasi-criminal," as argued by the Respondent, coupled by the fact that the Respondent failed to rebut the clear and convincing evidence that the Respondent knowingly intended to defraud the Medicaid program by appearing at the hearing, an inference can be made that the Respondent's testimony would have been adverse. See footnote 12, supra. See Daniel v. United States, 234 F. 2d 102, 106 (5th Cir. 1956). Although the inference could be drawn, it is not necessary to do so in order to support my findings and conclusions. My conclusion that the Respondent knowingly intended to submit the false claims in issue and intended to defraud the Medicaid program (Medi-Cal) is in part based on the conduct of the Respondent to cover-up for his illegal acts when it became known to the Respondent that he was being investigated; he attempted to get Ms. Warr and Freda Farris to cover-up for his illegal acts. Tr 1/159, 160; I.G. Ex 88/63, 64, 116, 117, 93D/42, 43. Also, I found Setseko Furuike, a psychiatric social worker with the State of California (Tr 188 to 217), to be an extremely forthright and credible witness. She testified that she reported the Respondent to John Shea, an investigator for the California Medi-Cal Fraud Unit, because the Respondent took a Medi-Cal sticker for a client of hers who lived in one of the Farris board and care homes, when in fact the client refused to even see the Respondent or any other doctor. She assisted John Shea in his investigation. Tr/197. She was intimidated by the Respondent and lost respect for him. Tr/220, 221. On the other hand, I found Mary Mason, although very accomplished in her field, not to be a credible witness. She attempted to attack the competency of several of the I.G.'s witnesses by way of bad reputation, bias, or incompetency to recall facts because of alcoholism or sloppiness in management of the Farris facilities and I did not accept her opinions about these witnesses because I found her to be biased; she winked at counsel for the Respondent while being questioned and did not seem to be completely forthright; in addition, she had little or no first hand knowledge of the direct matters in issue in this case.

VII. The Amount of The Proposed Penalty (as Modified), Assessment (As Modified), And Suspension Is Reasonable And Appropriate Under The Circumstances Of This Case, Within the Meaning And Intent Of The Act And Regulations

Having concluded that the Respondent is liable for a penalty, assessment, and suspension in this case because the I.G. proved liability and intent to defraud by clear and convincing evidence, I must decide the appropriateness of said proposed penalty, assessment and suspension.

I have already stated what the Act and Regulations provide and concluded that the Respondent presented 82 false claims (I.G. Ex 2 to 86, excluding 7, 77, and 83). The maximum penalty, assessment and suspension which could be imposed here are much greater than what the I.G. proposes. (See I.G. R Br at p.14 to 19.)

A. There Exist Substantial Aggravating Factors

The Act and Regulations provide that in determining the amount or scope of any penalty or assessment, the Secretary shall take into account: (1) the nature of the claims and the circumstances under which false claims were presented; (2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims; and (3) such other matters as justice may require. Guidelines are provided for determining appropriate assessments and penalties. See Regulations, §101.106 The Regulations require me to balance any aggravating against any mitigating factors. The Regulations provide that, where there are substantial aggravating circumstances, the amount of the penalty and assessment be set near or at the maximum amount. The regulatory guidelines are not binding on the ALJ. To determine the length of a suspension, the ALJ should consider the same guidelines outlined in Regulations §§101.106, 101.107. The Regulations also provide that these guidelines are not binding. Finally, the Regulations, §101.106(b)(4), provide that Respondent's resources will be considered.

I conclude that there exist many aggravating factors in this case. Many are discussed earlier in this decision and listed in the Findings of Fact. As noted, the Respondent billed for substantial sums and had a high degree of culpability. The record demonstrates that the false claims in issue constitute a small portion of a broad pattern or scheme to defraud the Medicaid program. Only one of these aggravating circumstances need exist for the Respondent's conduct to be deemed aggravating. The Inspector General has the burden of proving the existence of any such aggravating factors by clear and convincing evidence. 45 C.F.R. §101.114(b).

Specifically, it has been proven that circumstances under which the claims in question were presented by the Respondent were flagrant. This justifies the imposition of a substantial penalty and assessment. The culpability of the Respondent is so great that it is tantamount to criminal intent. Also, justice requires that I consider both the Respondent's efforts to cover up his scheme and his continued misconduct, nothwithstanding his pending criminal charges.

I found and concluded that the Respondent submitted 82 false claims over a three-month period. These claims are a large number for a small period of time. Each claim sought reimbursement for 45 to 50 minutes of individual psychotherapy, which is the highest reimbursable service for which the Respondent could have billed. Yet, if any service was rendered, it was for 2-15 minutes of group therapy. I feel that this is a situation which calls for the imposition of a penalty and assessment approaching the statutory maximum. When the overall scheme devised by the Respondent is considered, the imposition of a severe penalty and assessment is warranted. The Respondent systematically undertook to defraud the Medicaid program. As Mary Hottal testified, BSC relies on computers to audit claims for information which might indicate the claim is false or inaccurate and the computer audit function rejects any claims that are, on their face, incorrect or flags a provider who claims to have more hours of service than the norm for his provider profile. Tr 1/61-22. The Respondent's practice of falsely staggering the dates of service on his billings throughout the month for beneficiaries seen on only one day strongly suggests that he did so to avoid being caught. The Respondent created billings for what appeared to be a normal work day, and so his billings were unremarkable on their face.

While other psychiatrists in the area may not have been eager to accept retarded and schizophrenic board and care residents as patients (I.G. 87 at 4), the Respondent discovered that, by accepting these individuals as patients, while at the same time serving as program consultant to the board and care home, he could obtain large sums of money for little effort. His scheme was simple to implement and, to ensure that he had access to a volume of Medi-Cal stickers, he created a financial incentive for the board and care operators to elicit their cooperation. Deanna Corpuz and her husband owned and managed two board and care homes in San Jose, located at 580 South Sixth Street and 789 East San Carlos. I.G. Ex 88/53. When they needed a house psychiatrist, Ms. Corpuz contacted the Respondent, who agreed to become the house psychiatrist for the two Corpuz facilities under the following conditions: the Respondent would go

to each facility once a month to see the residents, monitor the residents' medication, and advise on "program enrichment;" in exchange, the Respondent would accept a Medi-Cal sticker for each resident who attended his group meeting. I.G. Ex 88/ 54-55. According to Ms. Freda Farris, she and Dr. Reynaud initiated a business relationship in 1973, shortly after she acquired her Main Street facility. The Respondent agreed to supervise the medical needs of the Main Street residents and conduct a monthly meeting with them. Id./66. She retained the Respondent in order to comply with the State licensing requirements that she have a program consultant visit the facility and sign patient progress reports. She paid for his services as consultant by giving him the residents' Medi-Cal stickers. Id./ 68. Having established himself as a house consultant, the Respondent implemented his practice of visiting each board and care home once a month, collected his Medi-Cal stickers, talked to the manager, took care of his duties to the facility (e.g., giving employees physical exams) chatted with the residents who were present and scheduled the next month's meeting. Id./31,50. The Respondent took stickers for both the residents who attended these monthly meetings and residents who did not. The Respondent would demand these stickers, claiming he did not need to see all the residents each month. Tr 1/66-167; I.G. Ex 88/13,77. Also, the Respondent took stickers for those residents who were not his patients; it was this latter situation which caused Ms. Furuike to file the complaint against the Respondent. Tr 1/195-196; I.G. Ex 88/1. The Respondent would combine the monthly meetings so that, rather than holding two meetings, he would see the residents of two homes in one meeting. I.G. Ex 87/5. The Respondent admitted to Investigators Shea and Camacho that these monthly visits were for the benefit of the board and care operator:

Dr. Reynaud: . . . when I go to this house
. . . this isn't just for them [patients].

Mr. Comacho: This is as a consultant?

Dr. Reynaud: But that the consulting, that's nothing to do with the treatment of the patient per se.

I.G. Ex 87/8, 9.

A provider is not allowed to accumulate short sessions of 10, 15 or 30 minutes, and bill them as one 45-50 minute session. This is not only established BSC policy (Tr 1/77-78), but reflects the view of the psychiatric community. I.G. Ex 94B/3, 12. Assuming the Respondent was permitted to accumulate a series of shorter sessions and represent them as one 50 minute session, the evidence overwhelmingly establishes that he never conducted any sessions of individual psychotherapy at the resident's home. The residents of the Farris board and care homes did not see the Respondent either at his office or at their residence (except for the monthly group meeting) except for Kathleen Marsh. Tr 1/152, 154-155, 159, 163, 167, 205-26; I.G. Ex 88/46, 48, 50, 51. The Respondent told Ms. Warr that he was supposed to get a Medicare sticker for each resident, whether seen by him or not, and he did not need to see the patients every month. I.G. Ex 88/77. He also admitted to investigators Shea and Camacho that he kept records of patient appointments with appointment books and patient ledger cards, and identified one such appointment book. I.G. Ex 87/9, 17. Yet, no appointment books were produced, despite repeated requests for production by the I.G. He alleged that the books could not be found.

Philip Yee, an investigator with the Medi-Cal Fraud Unit of the California Department of Justice, calculated the amount Dr. Reynaud improperly received for services allegedly provided to residents of six board and care homes. Using the Respondent's provider payment history for the period of 1973 through 1980 (Resp. TT; Tr 2/21-22), and the statements of board and care managers concerning the duration of his monthly sessions (I.G. 88), Yee determined the amount Dr. Reynaud was entitled to be paid and the amount he was overpaid. Tr 2/24. For the six facilities audited, Dr. Reynaud was overpaid $92,500.00 as a direct result of his filing false claims. I.G. Ex 90; Tr 2/24.

An additional aggravating factor which justice requires be considered is the attempt by the Respondent to interfere with the State Medi-Cal investigation. When he became aware of the

investigation, the Respondent called Ms. Warr and asked her to tell investigators that, in addition to the monthly meetings at her facility, he saw each resident individually for 45 minutes to an hour and told her Freda Farris, her boss, was going along with the cover-up. Tr 1/159-160; I.G. Ex 88/63-64. The Respondent also contacted Ms. Farris and asked her to cooperate in the cover-up. When Ms. Farris told him she did not want to jeopardize her license, the Respondent blurted that the State would have his license. Id. 116-117

In addition, the Respondent continued to file fraudulent Medi-Cal claims after his scheme had been uncovered and he had been indicted on eleven counts of presenting false claims and grand theft. This is evidenced by yet another complaint that the Respondent had taken Medi-Cal stickers of beneficiaries who were not his patients. The subsequent investigation revealed that the Respondent had not even modified his practice or scheme. Thus, a second criminal complaint was filed against the Respondent, which resulted in his conviction on charges of filing false Medi-Cal claims.

B. Rebuttal

In rebuttal, the Respondent offered the testimony of Mary Mason, who is the owner/operator of two board and care homes in San Jose. Tr 4/20. A total of nineteen Medi-Cal beneficiaries live at her homes. Tr 4/58. According to her, the Respondent spent five hours each month at each of her two facilities. Tr 4/59. He allegedly saw every resident individually during his monthly visit to the home, in addition to 45 to 50 minutes of individual psychotherapy at his office. Tr 4/60, 62. Ms. Mason claimed to be able to say precisely how long Dr. Reynaud spent with her clients because she claimed to have kept records of the time he spent at the monthly facility meetings (Tr 4/63), timed the office visits (Tr 4/62,66), and kept a record of his appointments. Tr 4/66-67. The only other board and care operator who takes the position that the Respondent routinely treated residents at his office, in addition to his monthly visit to the home, is Ms. Mildred Jordan, the owner/operator of Jordan Hall, located at 97 South 13th Street, San Jose. I.G. Ex 88/62. According to Ms. Jordan, the Respondent had been the "house doctor" since 1970 or 1972 and conducted monthly meetings, of an hour or two with all the residents. Id. Ms. Jordan claimed to have maintained a record of these monthly meetings.

Id. 62-63. When interviewed by investigator Shea, Ms. Jordan volunteered that her clients also walked to Dr. Reynaud's office where they saw him individually for forty-five minutes to one hour. Id. 63. Although she didn't attend these office sessions and didn't have any record of the appointments, Ms. Jordan could remember how long each session was "because her clients told her how long they took." Id. While the Respondent claims that these clients are credible witnesses, he argues that the clients of the Farris homes are not because they are retarded or schizophrenic.

The description of the Respondent by Ms. Mason and Ms. Jordan is quite a contrast to the description given by social workers, the owners/operators and managers of other residential facilities, and his own patients. This creates serious doubt as to the accuracy and veracity of the testimony of both Ms. Mason and Ms. Jordan. For example, while all other managers say the Respondent came to their facility once a month on a prearranged date (I.G. Ex 88/13, 27, 44, 47, 49, 50, 53, 58, 60), according to Ms. Mason, he would drop in throughout the month "for an hour, hour and a half and we wouldn't know that." Tr 4/61. While Ms. Jordan says the Respondent saw each one of the Jordan hall residents in his office for one hour of individual psychotherapy every month (I.G. Ex 88/63), the subsequent managers of that facility, Terry Moritz and Joan See, testified that from August through December 1981, only three residents went to the Respondent's office. I.G. Ex 94A at 21. Each of the three went to the office only once, and only two actually saw the doctor. Id./23-24, 38-39. Ms. Mason told investigator Shea that she didn't keep a record of the visits to the Respondent's office (I.G. 88/59), but when she testified at the hearing, she stated that she recorded the appointments on a calendar. Tr 4/67. She also stated that her residents made their own appointments with Dr. Reynaud (Tr 4/68.). The manager of the 457 North 5th Street facility, Ms. Davis, told investigators that Mary Mason made the office appointment. Id. at 51; I.G. Ex 88 at 85. Ms. Davis also stated that the residents returned from their rehabilitation projects at approximately 4:00 p.m. and the Respondent usually came to the facility between 4 and 6 p.m. Id. This is more consistent with his general pattern. Yet, Ms. Mason testified that the Respondent spent from 1 p.m. to 6 p.m. at each facility with the residents. Tr 4/59. Also she testified that the Respondent's monthly visit to the facility was held not to meet with her, but to talk to the residents. Tr 4/57. Ms. Mason denied that the Respondent spent several hours going over the facility program with her. Tr 4/71. Yet, when interviewed by Mr. Shea in 1980, she said the Respondent had been the facility program coordinator for eight or nine years and that she met with him once a month for one to two hours to discuss her program and client problems. I.G. Ex 88/57.

In addition to her testimony revealing inconsistencies, it reveals a strong bias in favor of the Respondent. While such a bias might be ascribed to a professional respect for the Respondent, I ascribe a different motivation; Dr. Reynaud was serving as her program consultant for several hours each month; while he generally charged $75 per hour for his services, (I.G. Ex 87/23), Ms. Mason received free services for a long period of time, even though she no longer does. Tr 4/70.

The Respondent asserts that the investigators did a sloppy job and that Ms. Furuike was biased against him. I find to the contrary; the investigators did a thorough job and lent much credible evidence to this case. While Ms. Furuike may have strong feelings against the Respondent, it is understandable and does not detract from her credibility because, as she testified:

> As a social worker, you learn to respect doctors, especially psychiatrists, and somehow they become on a pedestal. An it's very difficult - it was very difficult for me to question anything a psychiatrist was doing. It was also very difficult for me to accept the fact that some - a psychiatrist who I - a position that I hold in great esteem - would be doing something to me, very heinous and really a detriment to people who are helpless.

Tr 1/221.

C. <u>There Exists Only One Mitigating Factor</u>

The Respondent has the burden of proving by a preponderance of evidence any mitigating circumstances. §101.114(a). The Respondent argues that I should conclude that there exist mitigating factors in this case. He asserts that the services on the 85 claims constitute only a tiny portion of the Respondent's other activities. He asserts that no harm resulted from the false claims inasmuch as the services were actually "provided," and that the claims were not harmful to the patients. He asserts that to the extent he made false claims, it was in large measure due to error in using the codes. Finally, he asserts that he has a high standard of respect in the psychiatric community, that he is one of the few psychiatrists competent and willing to treat retarded people in the San Jose area, and he has already made restitution in the State Court.

While I can sympathize with the Respondent's embarrassment or chagrin over being subject to penalty, assessment and suspension herein and I find that he does share a good reputation for his competency in the psychiatric community, it is obvious that his contempt or arrogance of the myriad rules and restrictions of the Medicaid system or plain greed caused him to engage in an intentional scheme to get around the system that would not allow him to be paid for certain of the services he thought necessary for treatment that he provided to the board and care homes and the residents therein. As a result, he filed 82 false claims in a short period of time.

Moreover, the circumstances cited by the Respondent as mitigating are not mitigating or are so outweighed by the aggravating circumstances that the Respondent should consider himself fortunate to pay the amount proposed (less adjustments for the three claims found by me not to be false). However, there is one mitigating circumstance that I have considered, i.e., the claim (I.G. Ex 3) filed on behalf of Kathleen Marsh. The Respondent provided the services, but put the wrong date (November 29 instead of November 20). Although technically the claim is a false claim, there was no intent to defraud and the Respondent provided the service at another date (i.e., November 20). Accordingly, there are a total of four claims out of the 85 claims in issue that will be deemed not to be intentionally filed false claims.

D. The Assessment, Penalty And Suspension Are Supported By The Record In This Case (After Modifications).

The I.G. requests that I order penalties of $85,000, assessments of $3,016.38 22/, and a suspension for five years from Medicare and Medicaid programs.

I conclude that the Respondent shall be subject to penalties of $81,000 (82 false claims and 1 claim found to be a mitigating circumstance) 23/ and shall be suspended from participating in the Medicare and Medicaid programs for a period of five years.

The purpose of the assessments are to enable the United States to recover the damages resulting from false claims; this includes the reimbursement actually paid to the Respondent and the costs of investigating and prosecuting his unlawful conduct. The assessments

22/ Originally the I.G. proposed assessments of $5,000. See I.G. RB/14 to 15.

23/ Since I am unable to calculate the amount paid, I will deduct the amount claimed on each of the four claims, i.e., $60.

are "in lieu of damages." The assessments enable the United States to recoup damages without having to assume the burden of establishing actual damages. 48 Fed. Reg. 38831 (Aug. 26, 1983).

The penalties are intended to serve as a deterrent to future unlawful conduct by a particular Respondent or by other participants in the Medicare or Medicaid programs. In its report on the Act, the House Ways and Means Committee found that "civil money penalty proceedings are necessary for the effective prevention of abuses in the Medicare and Medicaid program. . . ." H.R. Rep. No. 97-158, 9th Cong., 1st Sess. Vol. III, 327, 329. I conclude that penalties of $81,000 are a sufficient deterrent to the Respondent.

Section 101.107 of the Regulations requires the same criteria used in determining assessments and penalties be considered in determining the length of any suspension imposed, including the presence of aggravating and mitigating factors; the purpose of the suspension is deterrence and protection of the Medicare and Medicaid programs. 48 Fed. Reg. 38832 (Aug. 26, 1983). A five year suspension in this case is also a sufficient deterrent to the Respondent.

There are many aggravating circumstances in this case which are discussed above. The Respondent was found to have engaged in a scheme to unlawfully secure Medicaid funds, to have attempted to cover up his scheme and to have contempt for the law by continuing to engage in a practice that had already resulted in indictments against him. This is a case where a strong deterrent is required. The Respondent is fortunate that the maximum penalties and assessments were not imposed and that he was not suspended for a greater length of time.

ORDER

Based on the evidence in the record and the Act and Regulations, it is hereby Ordered that the Respondent:

(1) Pay penalties of $81,000;

(2) pay assessments of $2,776.38; and

(3) be, and hereby is, suspended from the Medicare and Medicaid programs for a period of five (5) years from the date of this Decision and Order.

/s/

Charles E. Stratton
Administrative Law Judge