DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Appeals Board

Civil Remedies Division

In the Case of:	)	
	)	
The Inspector General,	)	DATE: August 15, 1989
	)	
- v. -	)	
	)	
Thuong Vo, M.D.	)	Docket No. C-45
and Nga Thieu Du,	)	DECISION CR 38
	)	
Respondents.	)	
	)	

DECISION OF ADMINISTRATIVE LAW JUDGE

Respondents requested a hearing to contest the proposed imposition against them, jointly and severally, of civil monetary penalties and assessments. Based on the law, regulations, and evidence adduced at the hearing in this case, I conclude that Respondents Thuong Vo, M.D. a/k/a Thomas Vo, M.D. (Respondent Vo) and Nga Thieu Du (Respondent Du) presented, or caused to be presented, claims for 64 items or services which they knew, had reason to know, or should have known were not provided as claimed. I impose civil monetary penalties of $128,000.00 and assessments of $3,890.00 against them, jointly and severally, for a total of $131,890.00.

BACKGROUND

On June 16, 1988, the Deputy Inspector General, Civil Administrative Division, notified Respondents that pursuant to authority delegated to her by the Secretary of Health and Human Services (the Secretary) and the Inspector General (the I.G.), she was proposing to impose civil monetary penalties and assessments against them. Specifically, she proposed that Respondents jointly and severally be penalized $128,000.00, and assessed $3,890.00, for a total of $131,890.00. She cited as legal authority for the proposal section 1128A of the Social Security Act, 42 U.S.C. 1320a-7a, as implemented by 42 C.F.R. 1003.100 et seq.

The Deputy Inspector General also proposed that Respondents be excluded from participating in the Title XVIII (Medicare), Title XIX (Medicaid), Title V (Maternal and Child Health Block Grant), and Title XX (Social Services Block Grant) programs for a period of ten years. She cited as legal authority for the proposed exclusions section 1128A(a) of the Social Security Act, 42 U.S.C. 1320a-7a(a).

The proposed penalties, assessments, and exclusions were based on the Deputy Inspector General's allegations that Respondents presented, or caused to be presented, to the California Medicaid program (Medi-Cal), claims, containing 64 items or services, requesting $1,945.00 in reimbursement for office visits and laboratory tests which were not provided as claimed. She asserted that Respondents knowingly improperly claimed reimbursement for services allegedly rendered on behalf of nonexistent individuals. Each of the allegedly false items or services was itemized as a separate count in an attachment to the Deputy Inspector General's notice to Respondents.

The Deputy Inspector General advised Respondents that she was proposing that the maximum penalties and assessments permitted by law be imposed against them. She told Respondents that her proposal was based on factors specified by regulations. These included:

1. the presence of aggravating circumstances in Respondents' case, including Respondents' participation, from August 1982 until February 1984, in an elaborate scheme to defraud government health care programs;

2. Respondents' substantial culpability, as evidenced by Respondents' knowledge that the services claimed had not been provided, and Respondents' conviction by a California court of crimes related to the claims at issue;

3. Respondents' not previously having been convicted of similar offenses;

4. the absence of information to suggest that the imposition of the proposed penalties and assessments would jeopardize Respondents' ability to continue as health care providers;

5. the presence of other aggravating factors, including Respondents' participation in a highly organized conspiracy to defraud Medi-Cal.

Respondent Vo timely requested a hearing. The request filed on his behalf did not request a hearing on behalf of Respondent Du. The case was assigned to me for a hearing and decision. I held a prehearing conference on November 15, 1988, at which counsel agreed that Respondent Vo's hearing request would be deemed to be a timely hearing request on behalf of Respondent Du.

The I.G. subsequently filed a motion for summary disposition against both Respondents as to three items or services itemized in the first three counts of the attachment to the Deputy Inspector General's notice. Respondents did not oppose this motion, and, on February 21, 1989, I issued a ruling which granted the I.G.'s motion.

My ruling was based on the I.G.'s undisputed assertion that Respondents pleaded guilty to crimes involving fraudulent presentation of Medi-Cal claims as enumerated in counts 1-3. I concluded that Respondents' convictions constituted "prior determinations" with respect to the items or services enumerated in counts 1-3. Therefore, pursuant to 42 C.F.R. 1002.114(c), the doctrine of collateral estoppel applied to these items or services. I made no finding in my ruling as to the appropriateness of penalties or assessments with respect to these false claims, and I stated that I would not preclude Respondents from offering evidence on the issue of the appropriateness of penalties or assessments.

I conducted a hearing in this case in Santa Ana, California on March 6, 1989. At the hearing, the I.G. withdrew the proposal to exclude Respondents from participating in health care programs under Titles V, XVIII, XIX, and XX.[1]

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[1] The I.G. previously excluded Respondent Vo from participating in Medicare, and directed that he be excluded from participating in State health care programs, for ten years, pursuant to section 1128(a) of the Social Security Act. Respondent Vo requested a hearing as to the exclusions. On October 31, 1988, Administrative Law Judge Paul Rosenthal issued a decision sustaining these exclusions. In the Matter of Thuong Vo, M.D., Docket No. HIS-000-93-7008, decided October 31, 1988. These exclusions were imposed under a different section of the law than that cited by the Deputy Inspector General in her notice letter to Respondents and are unaffected by the I.G.'s withdrawal of the proposal

(continued...)

At the completion of the hearing, I issued a schedule for the parties to file posthearing briefs and reply briefs. The I.G. timely filed a posthearing brief on April 26, 1989. Respondents did not file a posthearing brief. On May 19, 1989, I invited the parties to brief the possible impact on this case of a recent United States Supreme Court decision, United States v. Halper, No. 87-1383 (May 15, 1989). The I.G. timely filed a brief addressing the impact of the Halper decision. Respondents did not file a brief on Halper. On June 27, 1989, I issued an Order closing the record in this case.

ISSUES

The issues in this case are whether:

1. either Respondent presented, or caused to be presented, claims for items or services which he or she knew, had reason to know, or should have known were not provided as claimed, in violation of 42 U.S.C. 1320a-7a; and

2. penalties and assessments should be imposed against either Respondent and, if so, in what amount.

APPLICABLE LAW AND REGULATIONS

A. Statutes.

1. The Civil Monetary Penalties Law, 42 U.S.C. 1320a-7a.

B. Regulations.

1. 42 C.F.R. Part 1003--Civil Money Penalties and Assessments.

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[1] (...continued)
to exclude Respondents pursuant to section 1128A of the Social Security Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Respondent Vo is a physician. I.G. Ex. 6-2/315.[2]

2. Thuong Vo and Thomas Vo are the same person. Stip 8.

3. Respondent Du is the wife of Respondent Vo. Stip. 9.

4. Respondent Vo practiced medicine in California since 1982. I.G. Ex. 6-2/308.

5. Respondent Du assisted Respondent Vo with the business aspects of his medical practice. I.G. Ex. 5/29, 47.

6. Respondent Vo's practice included treating patients who were Medi-Cal beneficiaries. I.G. Ex. 6-2/310-311.

7. Medi-Cal is a program that provides needed medical care to those people who are eligible under the terms of California and federal laws. I.G. Ex. 6-1/9.

8. Respondent Vo sought and obtained authorization from Medi-Cal to be reimbursed by Medi-Cal for treating Medi-Cal beneficiaries. I.G. Ex. 6-1/10.

9. In California a provider can obtain reimbursement for treating Medi-Cal beneficiaries if he or she has qualified under the rules and regulations of the program and has a license in good standing. I.G. Ex. 6-1/11.

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[2] The stipulations, exhibits, transcript of the hearing, and memoranda will be cited as follows:

Stipulation	Stip. (number)
Joint Exhibit	J. Ex. (number)/ (page)
I.G.'s Exhibit	I.G. Ex. (number)/ (page)
Post-Hearing Brief of the Inspector General	I.G.'s Brief at (page)
Inspector General's Brief on the Issue of the Impact of the Double Jeopardy Clause on the Instant Action	I.G.'s Supplemental Brief at (page)
Statement of the Defenses of the Respondents	Rs.' Statement at (page)

10. The fiscal intermediary for Medi-Cal is Computer Sciences Corporation. I.G. Ex. 6-1/11.

11. Computer Sciences Corporation processes providers' claims for Medi-Cal reimbursement and authorizes payment of those claims. I.G. Ex. 6-11/12.

12. When a provider signs a claim form for Medi-Cal reimbursement, he certifies that he either personally provided the services for which reimbursement is sought, or that the services were provided under his direction by another person eligible under the Medi-Cal program to provide such services. J. Ex. 3; Tr. at 162.

13. In Respondent Vo's practice, Medi-Cal claims were prepared by office employees based on information supplied by Dr. Vo in patients' charts. I.G. Ex. 5/29.

14. Respondent Vo filled out the patient charts, left them in stacks for his staff, and signed completed claims before they were mailed. I.G. Ex. 5/29.

15. Respondent Vo signed all the Medi-Cal claims submitted by him for reimbursement. I.G. Ex. 6-2/319.

16. Respondent Du double checked claim forms before Respondent Vo signed them. I.G. Ex. 5/29.

17. Prior to March, 1983, the California Attorney General's Bureau of Medi-Cal Fraud (Fraud Bureau) received complaints that physicians treating members of the Vietnamese refugee community in Orange County, California were involved in a scheme consisting of writing prescriptions and billing Medi-Cal for patients they had never seen. I.G. Ex. 6-1/43.

18. In April, 1983, agents employed by the Fraud Bureau received information suggesting that Respondent Vo might have been part of this scheme. I.G. Ex. 6-1/42.

19. In May, 1983, the Fraud Bureau instituted an undercover operation with respect to Respondent Vo. I.G. Ex. 6-1/46.

20. Three such operations were eventually conducted concerning Respondent Vo. I.G. Ex. 5/1-14.

21. The first operation occurred on May 16, 1983. I.G. Ex. 5/2-5.

22. The second operation occurred on July 9,1983. I.G. Ex. 5/6-10.

23. The third operation occurred on August 30, 1983. I.G. Ex. 5/11-14.

24. In each of the three undercover operations, the Fraud Bureau created Medi-Cal identification cards which identified nonexistent Medi-Cal beneficiaries by name and identification number. I.G. Ex. 5/2-3, 6-7, 11; Tr. at 86-87.

25. During the May 16, 1983 undercover operation, operators in the service of the Fraud Bureau brought 13 Medi-Cal cards to Respondent Vo's office. I.G. Ex. 5/3; I.G. Ex. 6-1/48-49.

26. The names and Medi-Cal identification numbers on the 13 Medi-Cal cards were:

Dung Vu	30300564120050
Thanh Nguyen	30300564071003
La Nguyen	30300564071060
Yen Nguyen	30300564071004
Hung Nguyen	30300564089060
Thu Tran	30300564109060
Minh Tran	30300564120001
Giau Tran	30300564120001
Thanh Tran	30300564120060
Tung Le	30300564071050
Tron Nguyen	30300564071001
Meo Nguyen	30300564071002
Vinh Nguyen	30300564078060

I.G. Ex. 5/2-3.

27. The names on the 13 Medi-Cal cards were of nonexistent persons, and no individuals appeared at Respondent Vo's office purporting to be the persons named on the cards. I.G. 6-1/51-52.

28. On May 16, 1983, the operators received from Respondent Vo's office medical prescriptions made out to the names identified on the 13 Medi-Cal cards. I.G. Ex. 5/3-5; I.G. Ex. 6-1/48-49; Tr. at 81-82.

29. Subsequent to May 16, 1983, the Medi-Cal program received 13 claims for services signed by Respondent Vo, one for each of the nonexistent persons named on the Medi-Cal cards. I.G. Ex. 5/17; I.G. Ex. 6-1/50-51; I.G. Ex. 7/1 through 7/13.

30. The 13 claims represented that a total of 36 items or services were provided to the nonexistent persons named on the Medi-Cal cards. I.G. Ex. 7/1 through 7/13.

31. The total amount claimed for the 36 purported items or services was $1,120.00. I.G. Ex. 7-1 through 7-13.

32. The Medi-Cal program reimbursed Respondent Vo, based on the 13 claims. I.G. Ex. 6-1/50-51; I.G. Ex. 7-1 through 7-13.

33. The 36 items or services charged on the 13 claims are counts 1-36 on the attachment to the Deputy Inspector General's June 16, 1988 notice to Respondents (attachment to the notice).

34. During the July 9, 1983 undercover operation, operators in the service of the Fraud Bureau brought six Medi-Cal cards to Respondent Vo's office. I.G. Ex. 6-1/52-53.

35. The names and Medi-Cal identification numbers on the six Medi-Cal cards were:

Meo Nguyen	30300564071002
Thanh Nguyen	30300564071003
Tron Nguyen	30300564071001
La Nguyen	30300564071060
Tung Le	30300564071050
Yen Nguyen	30300564081004

I.G. Ex. 5/6-7.

36. The names on the six Medi-Cal cards were of nonexistent persons. I.G. Ex. 6-1/52-53.

37. On July 9, 1983, the operators received from Respondent Vo's office five medical prescriptions made out to the names identified on the six Medi-Cal cards. I.G. Ex. 5/8; I.G. Ex. 6-1/52-53.

38. Subsequent to July 9, 1983, the Medi-Cal program received one claim for services signed by Respondent Vo for one of the nonexistent persons named on the Medi-Cal cards. I.G. 6-1/53; Tr. at 87.

39. The nonexistent person for whom services were purportedly rendered by Respondent Vo was described on the Medi-Cal card as a six-year old child. I.G. 6-1/53.

40. In fact, no individual appeared at Respondent Vo's office purporting to be the six-year old child named on the Medi-Cal card. I.G. 6-1/53.

41. The claim represented that one item or service was provided to the nonexistent child named on the Medi-Cal card. I.G. Ex. 7-14.

42. The total amount claimed for the purported item or service was $30.00. I.G. Ex. 7-14.

43. The Medi-Cal program reimbursed Respondent Vo, based on this claim. I.G. Ex. 7-14.

44. The item or service charged on this claim is count 37 on the attachment to the notice.

45. During the August 30, 1983 undercover operation, nine Medi-Cal cards were delivered to Respondent Vo's office. I.G. Ex. 5/11-12; I.G. Ex. 6-1/53-54; Tr. at 88-89.

46. The names and Medi-Cal identification numbers on the nine Medi-Cal cards were:

Lien Doan	30300564101050
Duc Nguyen	30300564101060
Dien Nguyen	30300564101001
Lien Nguyen	30300564101002
Diep Nguyen	30300564087050
Khoa Nguyen	30300564087060
Binh Nguyen	30300564087001
Bon Nguyen	30300564087002
Hieu Nguyen	30300564087003

I.G. Ex. 5/11.

47. The names on the nine Medi-Cal cards were of nonexistent persons. I.G. Ex. 5/11.

48. The person who delivered the Medi-Cal cards received prescriptions, written by Respondent Vo, made out to some of the names of the nonexistent persons shown on the nine Medi-Cal cards. I.G. Ex. 6-1/54; Tr. at 88-89.

49. Subsequent to August 30, 1983, the Medi-Cal program received nine claims for services signed by Respondent Vo for each of the nonexistent persons named on the Medi-Cal cards. I.G. Ex. 6-1/55; I.G. Ex. 7-15 through 7-23; Tr. at 88-89.

50. The nine claims represented that a total of 27 items or services were provided to the nonexistent persons named on the Medi-Cal cards. I.G. Ex. 7-15 through 7-23.

51. The total amount claimed for the 27 purported items or services was $795.00. I.G. Ex. 7-15 through 7-23.

52. The Medi-Cal program reimbursed Respondent Vo, based on the nine claims. I.G. Ex. 7-15 through 7-23.

53. The 27 items or services charged on the nine claims are counts 38-64 on the attachment to the notice.

54. During the course of its investigation, the Fraud Bureau contacted individuals known as "drivers" who were paid by Vietnamese providers to deliver Medi-Cal patients or Medi-Cal cards to the providers. I.G. Ex. 5/1.

55. On February 15, 1984, pursuant to search warrants, agents of the Fraud Bureau seized 14 notebooks from Respondent Vo's office. I.G. Ex. 6-1/154.

56. Each of the notebooks contained information concerning the dates when drivers brought Medi-Cal patients or Medi-Cal cards to Respondent Vo's office and whether drivers had been paid for delivering the patients or cards. I.G. 6-1/154-155.

57. The time period covered by the 14 notebooks was August 17, 1982, to February 13, 1984. I.G. Ex. 5/31.

58. One of the persons who worked as a driver for Respondent Vo was an individual named Dung Vu. I.G. Ex. 5/1; I.G. Ex. 6-1/45.

59. Dung Vu delivered Medi-Cal cards to Respondent Vo's office, without bringing the persons identified by the cards. I.G. Ex. 5/78; I.G. Ex. 6-1/178.

60. Dung Vu's employment as a driver was arranged by Respondent Du. I.G. Ex. 5/78.

61. One of the 14 notebooks seized pursuant to search warrant was a driver's notebook which Respondent Du provided to Dung Vu. I.G. Ex. 5/78.

62. One of the persons who worked as a driver for Respondent Vo was an individual named Quoc Minh Van. I.G. Ex. 5/46.

63. Quoc Minh Van delivered Medi-Cal cards to Respondent Vo's office, without bringing the persons identified by the cards. I.G. Ex. 5/48.

64. Quoc Minh Van's employment as a driver was arranged by Respondent Du. I.G. Ex. 5/46-47.

65. One of the persons who worked as a driver for Respondent Vo was an individual named Mai Thi To Mac. I.G. Ex. 5/87.

66. Mai Thi To Mac's employment as a driver was arranged by Respondent Du. I.G. Ex. 5/87.

67. Mai Thi To Mac delivered Medi-Cal cards to Respondent Vo's office, without bringing the persons identified by the cards. I.G. Ex. 5/89.

68. Dung Vu, Quoc Minh Van, and Mai Thi To Mac were compensated for their services as drivers by Respondent Du. Tr. at 15

69. On November 28, 1984, Respondent Vo pleaded guilty in California state court to: one felony count of filing false Medi-Cal claims; one felony count of grand theft in excess of $25,000.00; and one felony count of conspiracy to cheat and defraud the Medi-Cal program. Stip. 11, 12; I.G. Ex. 2/7, 9, 15.

70. The felony count of filing false Medi-Cal claims to which Respondent Vo pleaded guilty is Count 1 of the amended felony complaint filed against him. I.G. Ex. 1/1-2.

71. The Medi-Cal claim which Respondent Vo admitted falsely filing is identified in the amended felony complaint as Medi-Cal claim number 31513409082. I.G. Ex. 1/2.

72. The three items or services contained in the claim referred to in Finding 71 are the three items or services identified as counts 1-3 the attachment to the notice.

73. Respondent Vo admitted in his guilty plea that he conspired with Respondent Du and other people, including drivers, to cheat and defraud Medi-Cal by billing for services that were never actually rendered. I.G. Ex. 2/7.

74. Respondent Vo admitted in his guilty plea that he had paid drivers to bring in Medi-Cal cards without patients. I.G. Ex. 2/7-8.

75. Respondent Vo admitted in his guilty plea that he filed claims with Medi-Cal which were false because the claims asserted that he provided treatment to patients when in fact he did not treat those patients. I.G. Ex. 2/8.

76. Respondent Vo admitted in his guilty plea that when he filed these false claims he knew they were false. I.G. Ex. 2/8.

77. Respondent Vo admitted in his guilty plea that he filed false claims with the intent of cheating and defrauding Medi-Cal. I.G. Ex. 2/8.

78. Respondent Vo admitted in his guilty plea that the amount of his theft from Medi-Cal exceeded $25,000.00. I.G. Ex. 2/9.

79. Respondent Vo admitted to receiving overpayments from Medi-Cal of $85,598.00 and agreed to make restitution of this amount. I.G. Ex. 2/9-10.

80. On November 28, 1984, Respondent Du pleaded guilty in California state court to one count of filing false Medi-Cal claims. Stip. 14, 15; I.G. Ex. 2 at 24.

81. Respondent Du admitted in her guilty plea that she had helped Respondent Vo file a false Medi-Cal claim, knowing that the representation on the claim was false. I.G. Ex. 2/21.

82. Respondent Du admitted in her guilty plea that she had helped Respondent Vo file a false Medi-Cal claim with the intent to steal from Medi-Cal. I.G. Ex. 2/21.

83. The felony count of filing false Medi-Cal claims, to which Respondent Du pleaded guilty, is Count 1 of the amended felony complaint filed against her. I.G. Ex. 1/1-2.

84. The Medi-Cal claim which Respondent Du admitted falsely filing is identified in the amended felony complaint as Medi-Cal claim number 31513409082. I.G. Ex. 1/2.

85. The three items or services contained in the claim referred to in Finding 83 are the three items or services identified at counts 1-3 of the attachment to the notice.

86. This proceeding is governed by the Civil Monetary Penalties Law, 42 U.S.C. 1320a-7a, (the Act) and by enabling regulations contained in 42 C.F.R. Part 1003.

87. The Act authorizes the Secretary to impose a civil monetary penalty and an assessment against any person who presents or causes to be presented, to an officer, employee or agent of any State, a claim for items or services under Title XIX (Medicaid) which that person knew or should have known was not provided as claimed. 42 U.S.C. 1320a-7a(a),(i)(2).

88. Prior to December 1987, the Act provided for imposition of a penalty, assessment, and exclusion against a person who filed a claim for an item or service where that person "knows or has reason to know" that the item or service was not filed as claimed. 42 U.S.C. 1320a-7a(a). Effective December 22, 1987, the phrase "should know" was substituted for the phrase "has reason to know." Pub. L. 100-203, section 4118(e) (1987). Section 4118(e)(3) of this law provided that the language substitution was intended to apply retroactively.

89. The Act provides for the imposition of a penalty of up to $2,000.00 for each item or service falsely claimed and assessments of up to twice the amount so claimed. 42 U.S.C. 1320a-7a(a).

90. The Act and regulations direct the Secretary or his or her delegate, in determining the amount or scope of any penalty or assessment imposed, to take into account both aggravating and mitigating factors. 42 U.S.C. 1320a-7a(d); 42 C.F.R. 1003.106.

91. Factors which may be considered as aggravating or mitigating include: the nature of the claims and the circumstances under which they were presented; the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims; and such other matters as justice may require. 42 U.S.C. 1320a-7a(d); 42 C.F.R. 1003.106.

92. If there are substantial or several aggravating circumstances, the aggregate amount of the penalty and assessment should be set at an amount sufficiently close to, or at, the maximum permitted by law, so as to reflect that fact. 42 C.F.R. 1003.106(c)(2).

93. In proceedings brought pursuant to the Act, the I.G. has the burden of proving, by a preponderance of the evidence, that a respondent presented, or caused to be

presented, claims for items or services which the respondent knew or should have known were not provided as claimed. 42 C.F.R. 1003.114(a).

94. In proceedings brought pursuant to the Act, a respondent has the burden of proving the existence of any mitigating factors. 42 C.F.R. 1003.114(d).

95. Respondents' guilty plea to Count 1 of the amended felony complaint filed against them constitutes a final determination with respect to the items or services specified in Count 1 of the amended felony complaint and listed as counts 1-3 of the attachment to the notice.

96. Respondents are, therefore, bound by that final determination in this proceeding.

97. Respondent Vo presented, or caused to be presented, to Medi-Cal, claims for the items or services listed in counts 1-64 of the attachment to the notice, and he knew that they were not provided as claimed. Findings 12-15, 25-79, 94-95.

98. Respondent Vo had reason to know that the items or services listed in counts 1-64 of the attachment to the notice were not provided as claimed. Findings 12-15, 25-79, 94-95.

99. Respondent Vo should have known that the items or services listed in counts 1-64 of the attachment to the notice were not provided as claimed. Findings 12-15, 25-79, 94-95.

100. Respondent Du presented, or caused to be presented, to Medi-Cal, claims for the items or services listed in counts 1-3 of the attachment to the notice, and she knew that they were not provided as claimed. Findings 80-83, 94-95.

101. Respondent Du presented, or caused to be presented, to Medi-Cal, claims for the items or services listed in counts 1-64 of the attachment to the notice, and she had reason to know that they were not provided as claimed. Findings 16, 60, 64, 66, 68, 80-83, 94-95.

102. Respondent Du should have known that the items or services listed in counts 1-64 of the attachment to the notice were not provided as claimed. Findings 16, 60, 64, 66, 68, 80-83, 94-95.

103. Respondent Vo presented, or caused to be presented, claims over a lengthy period of time for items or

services that were not provided as claimed. Findings 21-23, 25-52.

104. Respondent Vo presented, or caused to be presented, claims for a substantial number of items or services that were not provided as claimed. Finding 97.

105. Respondent Du presented, or caused to be presented, claims for a substantial number of items or services that were not provided as claimed. Findings 100, 101.

106. Respondent Vo claimed substantial reimbursement for items or services that were not provided as claimed. Findings 31, 42, 51.

107. The items or services presented by Respondent Vo which were not provided as claimed were part of a pattern of false claims by Respondent Vo against the Medi-Cal program. Findings 54-79.

108. The items or services presented by Respondent Vo, which were not provided as claimed, and the pattern of false claims engaged in by Respondent Vo were part of a conspiracy to defraud Medi-Cal, of which Respondent Vo was a participant. Findings 54-79.

109. The unlawful gains obtained by way of this conspiracy greatly exceeded the amount claimed for the items or services listed as counts 1-64 in the attachment to the Deputy Inspector General's June 18, 1988 notice to Respondents. Findings 78-79.

110. Respondent Du was a participant with Respondent Vo in this conspiracy to defraud Medi-Cal. Findings 16, 60, 64, 66, 68, 80-83.

111. Respondents have not established any of the allegations made by them which could be construed as mitigating factors.

112. Respondents have not established that they were entrapped into presenting the claims for items or services listed as counts 1-64 in the attachment to the notice.

113. Respondents have not established that they were targets of a plan to single out Vietnamese providers for prosecution.

114. Respondents have not established that their actions were motivated by sympathy for the relatives in Vietnam of Vietnamese Medi-Cal patients.

115. Respondents have not established that the imposition against them of penalties of $128,000.00 and assessments of a $3,890.00, for a total of $131,890.00, will jeopardize their ability to continue as health care providers.

116. Penalties of $128,000.00 and assessments of $3,890.00 against Respondents, jointly and severally, are appropriate in this case.

ANALYSIS

1. Respondents presented, or caused to be presented, claims for items or services which they knew, had reason to know, or should have known were not provided as claimed.

Based on the evidence of record, I conclude that Respondent Vo presented, or caused to be presented, claims for 64 items or services that he knew, had reason to know, or should have known were not provided as claimed.

I conclude further, based on the principles of collateral estoppel contained in 42 C.F.R. 1003.114(c), that Respondent Du presented, or caused to be presented, claims for three items or services that she knew were not provided as claimed. I conclude that the I.G. did not prove that Respondent Du knew that the items or services listed as counts 4-64 in the attachment to the notice were not provided as claimed. However, I conclude that Respondent Du had reason to know or should have known that these items or services were not provided as claimed.

a. Respondent Vo.

The first element of proof which the I.G. must establish in order to prove liability in a case brought pursuant to the Act is that a respondent presented, or caused to be presented, the claims for the items or services at issue. 42 U.S.C. 1320a-7a(a); 42 C.F.R. 1003.102. Respondent Vo caused the items or services at issue to be presented. He prepared the medical records on which the claims for the items or services were based, and he personally signed the claim forms on which the items or services were presented to Medi-Cal. Findings 13-15; 29, 38, 49.

The next element of proof which the I.G. must establish is that the items or services were not provided as

claimed. 42 U.S.C. 1320a-7(a)(1); 42 C.F.R. 1003.102. In this case there can be no doubt that the 64 items or services at issue were not provided as claimed. This is so because the patients to whom these alleged items or services were purportedly rendered did not exist.

The evidence establishes that, in early 1983, the Fraud Bureau received complaints that physicians, including Respondent Vo, were writing prescriptions and making claims to Medi-Cal for services provided to patients who did not exist. Findings 17-18. Agents of the Fraud Bureau created Medi-Cal cards for nonexistent persons and engaged in three undercover operations with respect to Respondent Vo. Findings 20, 24. All of the 64 claims for items or services at issue in this case were purportedly rendered to the nonexistent persons whose names and Medi-Cal identification numbers appeared on these cards. Findings 29-30, 33, 38-41, 44, 50-51, 53. As there were no patients to whom services could have been rendered, there were no services. The "services" for which Respondent Vo presented claims described in counts 1-64 were never provided to anyone and, therefore, were not provided as claimed.

The final element of proof which the I.G. must establish in proving liability pursuant to the Act is that a respondent bears requisite culpability for the claims at issue. The Act presently provides that this test is satisfied where it is shown that a respondent either knows, or should know, that the items or services at issue were not provided as claimed. 42 U.S.C. 1320a-7a(a)(1)(A).[3]

Respondent Vo knew that the items or services at issue were not provided as claimed. He admitted orchestrating a scheme to steal from Medi-Cal. Finding 73. He admitted paying drivers to bring Medi-Cal cards without

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[3] The I.G. requested that I determine whether Respondents had reason to know that the items or services listed at counts 1-64 in the attachment to the notice were not provided as claimed. I.G.'s Brief at 37. The I.G.'s request is premised on the fact that no decision has been issued by any court concerning Congress' December 22, 1987 retroactive application of the "should know" standard to claims for items or services. Given that this case is one of first impression, I use the "knows" and "should know" standard of the 1987 revision, and the pre-revision "has reason to know" standard, to decide Respondents' culpability.

patients. Finding 74. He admitted knowingly presenting false claims for services that he never rendered. Findings 75-76. Respondent Vo admitted that his intent was to cheat and defraud Medi-Cal. Finding 77. He admitted stealing more than $25,000.00 from Medi-Cal. Finding 78. He admitted that three of the items or services at issue in this case, listed in counts 1-3 of the attachment to the notice, were falsely claimed in furtherance of his criminal scheme. Findings 71-72. The other items or services at issue in this case arose from the same undercover operations and transactions that led to these admissions. Findings 25-53. It is reasonable to infer that they are also part of Respondent Vo's scheme to defraud Medi-Cal.

Respondent Vo personally created the medical records upon which his Medi-Cal claims were based. Findings 13-14; see I.G. Ex. 6-2/333. Inasmuch as the claims at issue relate to patients who do not exist, Respondent Vo had to fabricate the records upon which the claims were based. When Respondent Vo fabricated these records, he had to have done so intending that false claims would be predicated upon them. There would have been no other reason for him to create false patient records.

Respondent Vo denies that he knew that the items or services at issue were not provided as claimed or that he ever intended to steal money from Medi-Cal. I.G. Ex. 6-1/312. He premises his denials on his assertion that he signed claims "weeks, or 20 days or one month after I saw the patient," thereby implying that by the time he signed the claims he no longer remembered the items or services that the claims represented. Id.

I conclude that this assertion is largely incredible. The record establishes that many of the claims at issue were presented on the same day or within a few days of the "treatments" on which they were allegedly based. I.G. Ex. 7-1-7-17. Several of the claims arising from the May 18, 1983 undercover operation were presented within one week of that date. All except one of the claims arising from the August 30, 1983 undercover operation were presented on that same day. I conclude that Respondent Vo certainly remembered fabricating treatment records for these claims when he signed the claims.

Assuming, for argument's sake, that Respondent Vo could not remember whether he had fabricated the items or services presented in a given claim at the moment he signed the claim form, he nevertheless knew that he was presenting claims for items or services that were not

provided as claimed, including the items or services at issue in this case. Respondent Vo deliberately falsified the records on which claims were based in furtherance of his scheme to defraud Medi-Cal. When he fabricated treatment records, he knew that, ultimately, false claims would be presented based on those false records. He thus knew that he was presenting claims for items or services that were not provided as claimed, and he had specific knowledge that false claims would be presented based on the fabricated records he created. I conclude that this level of knowledge suffices to satisfy the "knows" standard of 42 U.S.C. 1320a-7a(a), even if days or weeks after falsifying the treatment records Respondent Vo no longer remembered which record pertained to which claim.

Respondent Vo had reason to know that the items or services at issue were not provided as claimed. The "reason to know" standard contained in the Act prior to December 22, 1987 created a duty on the part of a provider to prevent the submission of false or improper claims where: (1) the provider had sufficient information to place him, as a reasonable medical provider, on notice that the claims presented were for services not provided as claimed, or (2) there existed pre-existing duties which would require a provider to verify the truth, accuracy, and completeness of claims. The Inspector General v. George A. Kern, M.D., Docket No. C-25, decided August 26, 1987, at pp. 5-7; see The Inspector General v. Frank P. Silver, M.D., Docket No. C-19, Decision and Order on Remand, decided July 2, 1987, at p. 24.

The "reason to know" standard is a less stringent standard for liability under the Act than the "knows" standard. In this case, evidence concerning Respondent Vo's activities and knowledge satisfies both the "reason to know" and the "knows" standards.

The evidence in this case satisfies both elements of the "reason to know" test as applied to Respondent Vo. Because Respondent Vo was generating the fabricated patient records on which false claims were based, he had sufficient information to place him on notice that the claims presented for the items or services at issue were for services not provided as claimed. Furthermore, Respondent Vo was under a pre-existing duty to verify the truth, accuracy, and completeness of the claims he signed, including the claims presented for the items or services at issue. By his own admission, he ignored this duty. I.G. Ex. 6-2/312.

On each claim form that Respondent Vo signed, he certified that the information contained on the form was

true, accurate, and complete and that he agreed to be bound by, and comply with, the statements and conditions on the back of the form. J. Ex. 3. The back of each claim form signed by Respondent Vo contained a statement under the heading "IMPORTANT" which provided in relevant part that:

> The services listed on this form have been personally provided to the patient by the provider or, under his direction, by another person eligible under the Medi-Cal Program to provide such services, and such person(s) are designated on this form. The services were, to the best of the provider's knowledge, medically indicated and necessary to the health of the patient. The provider understands that payment of this claim will be from Federal and/or State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and/or State laws.

J. Ex. 3.

Respondent Vo had a duty to investigate whether the facts represented on any claim were true before signing the form. Every form that he signed explicitly stated that obligation. Respondent Vo represented that he had complied with this duty every time he signed a claim form. However, Respondent Vo asserted that he signed these forms without recalling the patients whose services they recorded or the treatments claimed for reimbursement. I.G. Ex. 6-2/312.

Respondent Vo should have known that the items or services listed in counts 1-64 of the attachment to the notice were not provided as claimed. The "should know" test for liability encompasses a less stringent standard than the "reason to know" test. See In the Matter of The Inspector General v. Frank P. Silver, M.D., Docket No. C-19, Opinion of Deputy Under Secretary, decided April 27, 1987. "Should know" subsumes reckless disregard for the consequences of a person's acts. The test also subsumes negligence in preparing and submitting, or in supervising the preparing and submitting of, claims. Mayers v. U.S. Dept. of Health and Human Services, 806 F.2d 995 (11th Cir. 1986), cert. denied, U.S. (1988).

If nothing else, Respondent Vo's conduct in signing claim forms constituted reckless disregard for the truth of the contents of those forms. I have not accepted as credible Respondent Vo's testimony that he was unaware of what he was signing. But assuming he was truthful on this point,

his testimony establishes that he was signing claim forms without any regard for what those forms contained. That amounts to reckless conduct, which satisfies the "should know" standard.

b. Respondent Du.

Respondent Du admitted filing false claims with Medi-Cal, and the false claims she admitted filing include the three items or services specified in counts 1-3 of the attachment to the notice. I conclude, based on these admissions, and the terms of 42 C.F.R. 1003.114(c), that she presented or caused to be presented the items or services enumerated at counts 1-3 and that she knew that they were not provided as claimed.

I conclude that Respondent Du presented, or caused to be presented, the claims containing the items or services included in counts 4-64 of the attachment to the notice. She was employed in Respondent Vo's office; her duties included double-checking claims for Medi-Cal reimbursement before they were signed by Respondent Vo and presented. Finding 16. She, therefore, directly participated in the chain of events which resulted in the presenting of these items or services.

The I.G. did not establish that Respondent Du knew that the items or services enumerated in counts 4-64 were not provided as claimed. Although there is considerable evidence in this case to establish that Respondent Du was a co-conspirator in the scheme to defraud Medi-Cal, the record does not establish that Respondent Du assisted Respondent Vo in fabricating patient treatment records. See Findings 54-68; 80-85. Therefore, unlike Respondent Vo, there is no evidence which establishes that she had direct knowledge that particular claims were based on falsified records.

However, Respondent Du had reason to know that the items or services listed in counts 4-64 of the attachment to the notice were not provided as claimed. Respondent Du had sufficient information to place her on notice that she had presented claims for items or services, including the items or services at issue in this case, which were not provided as claimed. She abetted Respondent Vo's actions. She was the recruiter and the paymaster of the drivers. Findings 56-68. She encouraged drivers to bring Medi-Cal cards to her, without patients, for the obvious purpose of generating false Medi-Cal claims. Id. The claims for the items or services at issue in this case are the end result of Respondent Du's actions. The evidence concerning Respondent Du therefore satisfies the

first element of the "reason to know" test described supra.

Respondent Du should have known that the items or services listed in counts 4-64 were not provided as claimed. Even if she did not know whether any particular claim was false, she knew that many of them had to be false. She was directly involved in preparing claims, including double-checking claims for accuracy. She manifested a reckless disregard for the truthfulness of the claims she assisted in preparing.

2. A penalty of $128,000.00 and an assessment of $3,890.00 against Respondents, jointly and severally, is appropriate in this case.

The remedial purpose of the Act is to protect government financed health programs from fraud and abuse by providers. Mayers, supra, 806 F.2d at 997. The penalty and assessment provisions of the Act are designed to implement this remedial purpose in two ways. One is to enable the government to recoup the cost of bringing a respondent to justice and the financial loss to the government resulting from the false claims presented by that respondent. The other is to deter other providers from engaging in the false claims practices engaged in by a particular respondent. Id. at 999.

The Act and implementing regulations provide that a penalty of up to $2,000 and an assessment of not more than twice the amount claimed may be imposed on a respondent for each item or service which is established as not having been provided as claimed. 42 U.S.C. 1320a-7a(a); 42 C.F.R. 1003.103-104. In this case, the maximum penalties which I may impose against each Respondent are $128,000.00, based on the presentation for payment of 64 items or services which were not provided as claimed. The maximum assessments which I may impose are $3,890.00, based on total claims for $1,945.00 for the items or services at issue in this case.[4]

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[4] A recent United States Supreme Court decision, United States v. Halper, No. 87-1383 (May 15, 1989), held that under some circumstances the imposition of civil penalties may violate the Double Jeopardy Clause of the Sixth Amendment to the United States Constitution. The Court held that the imposition of a penalty under the False Claims Act, 31 U.S.C. 3729-3231, could constitute prohibited double jeopardy in the narrow circumstance where there existed a prior federal criminal conviction

(continued...)

Regulations prescribe that, in determining the amount of a penalty and assessment, I must consider as guidelines factors which may either be mitigating or aggravating. 42 C.F.R. 1003.106. These include: (1) the nature of the claim or request for payment and the circumstances under which it was presented, (2) the degree of culpability of the person submitting the claim or request for payment, (3) the history of prior offenses of the person submitting the claim or request for payment, (4) the financial condition of the person presenting the claim or request for payment, and (5) such other matters as justice may require. 42 C.F.R. 1003.106(a).

The I.G. has the burden of proving the presence of aggravating factors. 42 C.F.R. 1003.114(a). A respondent has the burden of proving the presence of mitigating factors. 42 C.F.R. 1003.114(c). The regulations provide that, in cases where mitigating factors preponderate, the penalty and assessment should be set sufficiently below the maximum permitted by law. 42 C.F.R. 1003.106(c)(1). The regulations also provide that, in cases where aggravating factors preponderate, the penalty and assessment should be set close to the maximum permitted by law. 42 C.F.R. 1003.106(c)(2).

The Act has been interpreted to permit the imposition of a penalty and assessment which exceeds the amount actually reimbursed to a respondent for items or services not provided as claimed. Chapman v. U.S. Dept. of Health & Human Services, 821 F.2d 523 (10th Cir. 1987); Mayers, supra, 806 F.2d at 999. This reflects the legislative determination that activities in violation of the act "result in damages in excess of the actual amount

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[4] (...continued)
for the false claims for which the civil penalty was imposed and where there was not even a remote relationship between the amount of the penalty and the cost to the government resulting from the false claims. This case is distinguishable from Halper, because Respondents were convicted on state charges and not on federal charges. Double jeopardy does not apply to a subsequent federal prosecution based on facts which led to a state conviction. Abbate v. United States, 359 U.S. 187 (1959); and Chapman v. U.S. Dept. of Health and Human Services, supra, 806 F.2d 523, 529. Therefore, Halper does not apply to this case and, in particular, has no limiting effect on the amount of the penalties and assessments I may impose.

disbursed by the government to the fraudulent claimant." Mayers, supra, 806 F.2d at 999.

I have considered Respondents' conduct in light of the evidence and the Act's remedial purpose and regulatory criteria, and I conclude that the maximum penalty and assessment permitted by the Act should be imposed against each Respondent. The I.G. established many aggravating factors with respect to each Respondent. Neither Respondent established any mitigating factors.

a. Respondent Vo.

Respondent Vo presented or caused to be presented the items or services at issue over a four month period, a lengthy period of time. Finding 103. The 64 items or services which Respondent Vo presented or caused to be presented for payment which were not provided as claimed constitute a substantial number of such items or services. Finding 104. Respondent Vo claimed $1,945.00 as reimbursement for the items or services at issue, and this is a substantial amount. Finding 106.

These circumstances are aggravating factors as defined by regulation. 42 C.F.R. 1003.106(b)(1). The presence of these factors alone would, absent proof of mitigation, justify my imposing a substantial penalty and assessment against Respondent Vo. However, there exist other aggravating circumstances in this case which are far more serious than those just cited.

The evidence establishes that the items or services at issue were but a small part of a pattern of fraudulent conduct perpetrated by Respondent Vo. Respondent Vo conspired to defraud Medi-Cal. In order to effect his plan, he enlisted the services of many individuals, including those of Respondent Du. His scheme consisted of a concerted and, for a time, successful plan to deceive Medi-Cal's intermediary into paying Respondent Vo for falsified Medi-Cal services.

When considered in its entirety, the evidence in this case proves that Respondent Vo engaged, over a long period of time, in a well-organized, sophisticated, and massive theft from a government-financed health care program. Findings 73-79; 107-108. The scope and effect of this conspiracy can, in some respects, be measured by that to which Respondent Vo admitted. He admitted to stealing in excess of $25,000.00 from Medi-Cal and to being overpaid $85,598.00 by Medi-Cal. Findings 78-79. Moreover, there is evidence beyond Respondent Vo's admissions which suggests an even greater scope to the

conspiracy than that to which he admitted. The drivers' notebooks, seized from Respondent Vo's office, record transactions spanning a 17-month period. Finding 57. Individuals identified as drivers admit to supplying Respondents with Medi-Cal cards during this period. Findings 59, 63, 67.

Respondent Vo, therefore, manifests a high degree of culpability, an aggravating factor described in 42 C.F.R. 1003.106(b)(2). Furthermore, the items or services which are the subject of this case are merely an element in a pattern of unlawful conduct by this Respondent which comprises his conspiracy to defraud Medi-Cal. A similar pattern of unlawful conduct was found to be an aggravating circumstance in the Mayers case, and the court held that it amply justified the penalty and assessment imposed on the respondents in that case. 806 F.2d at 999.

Respondent Vo established no mitigating factors. He offered no evidence to show that imposing against him the penalties and assessments sought by the I.G. would jeopardize his ability to continue as a health care provider. See 42 C.F.R. 1003.106(b)(4).[5] He did not rebut the I.G.'s case concerning the nature of his offense or the scope and pattern of his conduct.[6]

Respondent Vo made several allegations concerning this case which, if proven, might arguably constitute mitigating factors. Respondent Vo alleged that he was singled out as part of a campaign in California by State government against Vietnamese providers, that he was entrapped into filing the claims for the items or services at issue, and that he presented, or caused to be presented, the claims for the items or services at issue because of his compassion for members of the Vietnamese community in California and relatives in Vietnam of members of this community.

Respondent Vo offered no credible evidence to substantiate these allegations. His assertion that he was singled out for investigation and prosecution by State authorities because of his ethnic origin is

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[5] Indeed, evidence establishes that in 1983, Respondent Vo was paid in excess of $515,000.00 by Medi-Cal alone. I.G. Ex. 6-2/318-319.

[6] Respondents rested their case without offering a single witness or exhibit. As noted supra, Respondents have not filed a posthearing brief.

premised exclusively on the fact that undercover investigations were conducted at the same time against several Vietnamese providers. The logical explanation for this is that complaints had been made against Vietnamese providers, including Respondent Vo. Finding 17. It would have been illogical for the Fraud Bureau to target its investigation against parties other than the subjects of the complaints.

There is no evidence that Respondent Vo was entrapped when he obtained false Medi-Cal cards and presented, or caused to be presented, claims for items or services that were not provided as claimed. To the contrary, the evidence establishes that Respondent Vo actively sought these cards, acquired them, and generated false claims based on them. Findings 73-79.

Respondent Vo's assertion that his claims activity was an offshoot of his compassion for Vietnamese refugees and their relatives in Vietnam is self-serving and not credible. Respondent Vo's argument rests on his uncorroborated testimony that he wrote prescriptions based on Medi-Cal cards provided to him so that Vietnamese patients could purchase prescription medicines to send to their relatives in Vietnam. I.G. Ex. 6-2/313-314; see Rs.' Statement at 2, 4, 6. The argument is contradicted by the admissions he made in connection with his guilty plea to state criminal charges. Findings 73-79. Moreover, there is no credible evidence in this case to show that, even if Respondent Vo wrote the fraudulent prescriptions out of misguided compassion for his countrymen, he was required, as an adjunct to writing prescriptions, to fabricate Medi-Cal claims. This case is not about false prescriptions; it is about false Medi-Cal claims, the proceeds of which Respondent Vo used to his own benefit.

I conclude that the I.G. established Respondent Vo's conduct to have been costly to the government. Respondent Vo admitted that his unlawful conspiracy netted more than $25,000.00. The cost to the government of investigating the conspiracy and bringing cases against Respondent Vo certainly greatly exceeded the amount claimed in the items or services at issue in this case. However, these costs are only a pale indicator of the costs to the Medi-Cal program which resulted from the provider fraud established in this case. The real costs arising from this misconduct include the widespread corruption which the conspiracy generated, and the loss of scarce resources which otherwise might have been used for legitimate medical needs. Imposing the maximum penalties and assessments permitted by law will serve to

recoup these costs. It will also send a message to other providers not to engage in the kind of misconduct engaged in by Respondent Vo.

b. Respondent Du

The evidence adduced by the I.G. in this case establishes Respondent Du to be as culpable as her co-conspirator, Respondent Vo. Respondent Du played a critical role in the conspiracy to defraud Medi-Cal. Without her involvement and her contribution, Respondent Vo's scheme to defraud Medi-Cal would certainly have been less successful.

As is noted above, Respondent Du's role in the conspiracy was to recruit drivers and pay them for Medi-Cal cards. Findings 54-68. Respondent Du was the drivers' primary point of contact with the conspiracy. She determined the fees the drivers were to receive for their services and maintained written records of the drivers' activities. I.G. Ex. 5/78. Respondent Du admitted her culpability as a co-conspirator with Respondent Vo in her guilty plea to state criminal charges. Findings 81-82.

The identical aggravating factors apply to Respondent Du as to Respondent Vo. Respondent Du's involvement in the conspiracy coincides with Respondent Vo's involvement. It is reasonable to attribute to Respondent Du, jointly with Respondent Vo, the effects of the conspiracy, including the costs generated thereby.

Respondent Du has not established the presence of mitigating factors in her case. The same allegations were filed on her behalf as were filed on behalf of Respondent Vo and, as with Respondent Vo, Respondent Du offered no evidence to substantiate these allegations.

I conclude that the identical considerations apply in determining appropriate penalties and assessments against Respondent Du as are applicable to Respondent Vo. As an integral member of the conspiracy, Respondent Du bears the same burden for the resulting costs to the government as does Respondent Vo.

CONCLUSION

For the reasons set forth in this decision, I impose civil monetary penalties of $128,000.00, and assessments of $3,890.00, for a total of $131,890.00, against Respondents Vo and Du, jointly and severally.

/s/

Steven T. Kessel
Administrative Law Judge