BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
JOHN N.S. RAJARATNAM, M.D.	OAH No: L2007010013
	Case No: 04-2004-163478
Physician's and Surgeon's Certificate No. A-51207	
Respondent.	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby accepted and adopted by the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, as its Decision in the above entitled matter.

This Decision shall become effective at 5:00 p.m. on January 2, 2008.

DATED December 3, 2007

MEDICAL BOARD OF CALIFORNIA

Barbara Yaroslavsky
Chair, Panel B
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	Case No. 04-2004-163478
JOHN N.S. RAJARATNAM, M.D.	OAH No. L2007010013
Physician's and Surgeon's Certificate No. A 51207,	
Respondent.	

PROPOSED DECISION

This matter was heard by Eric Sawyer, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, on June 11-14, July 6, and September 6-7, 2007, in Santa Ana.

Martin W. Hagan, Deputy Attorney General, represented Complainant. Bradley N. Garber, Esq., represented John N.S. Rajaratnam, who was present each hearing day.

The record was closed and the matter was submitted for decision on September 7, 2007. However, by an order dated September 24, 2007, the ALJ re-opened the record to request a missing portion of exhibit 81 and clarification from the parties regarding the admission of exhibits 122-127. The requested information was timely provided by the parties. The ALJ issued an order which clarified the admission of exhibits 122-127. The record was re-closed and the matter was re-submitted for decision on October 12, 2007.

FACTUAL FINDINGS

Parties & Jurisdiction

1. David T. Thornton (Complainant) brought the First Amended Accusation in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board). The First Amended Accusation superseded the original Accusation filed in this matter. John N.S. Rajaratnam, M.D. (Respondent) submitted a Notice of Defense, which requested the hearing that ensued.

2. On September 22, 1992, the Board issued Physician's and Surgeon's Certificate No. A 51207 to Respondent. The certificate was in full force and effect at all times relevant and will expire on July 31, 2008, unless renewed.

Background Information

3. Respondent was born in India. After graduating from medical school, he practiced five years as a primary care physician in India. Respondent immigrated to the United States in 1988. He successfully completed required board examinations in this country. He worked as a psycho-pharmacology researcher in Illinois for one year. Respondent completed his residency program in 1992. He completed his post-doctoral work at U.C.L.A. in 1994. Respondent is married. He and his wife have three small children.

4. In July 1994, Respondent was retained by the County of Orange Health Care Agency (COHCA) as a contract Psychiatrist. At first he worked part-time. On August 16, 1996, Respondent was hired as a regular, full-time employee of COHCA, as a Community Mental Health Psychiatrist. Respondent's duties in that position generally included, but were not limited to, assessing, diagnosing and administering treatment to patients; providing psychiatric medications when appropriate; developing medication plans; providing crisis intervention and emergency medications when appropriate; and preparing comprehensive, concise and accurate reports and records.

5. By 2002, Respondent's weekly work schedule was as follows. On Mondays, he worked four hours in the morning for a private practice in Burbank, and then worked for COHCA from 1:00 p.m. to 9:00 p.m. On Tuesdays, Wednesdays and Fridays, Respondent worked for COHCA from 9:00 a.m. to 9:00 p.m. On Thursdays, Respondent worked as a contract psychiatrist with the Aspen Day Treatment Center (Aspen), an entity separate from COHCA. Respondent also periodically responded to emergency calls for patients during the evenings and on weekends. He was also occasionally called for duty on COHCA business when he was working for the Burbank practice or Aspen. Respondent performed his services for COHCA at various clinics, which further complicated his schedule.

6. As an employee of COHCA, Respondent was, or should have been, aware of the following requirements: conform to the code of ethics and standards for the medical profession; keep separate any work done for the COHCA and any contract employers, such as Aspen; take reasonable precautions to ensure that documentation relating to patient treatment and billing was accurate and in compliance with any and all applicable laws; ensure that no false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind were submitted; and to bill only for services actually rendered and fully documented.

7. Most, if not all, of Respondent's work for COHCA and Aspen was for patients covered by Medi-Cal. Pertinent rules and regulations required the exact number of minutes billed to Medi-Cal to correspond to actual performance, i.e. for an hour of actual service Medi-Cal could be billed no more than 60 minutes.

8. On or about August 4, 2003, COHCA's Office of Compliance received an anonymous complaint concerning Respondent's billing practices. The anonymous complaint prompted a random sample review of Respondent's documentation and billing records. The random sampling revealed discrepancies in some of his billing materials. A full audit was therefore conducted of Respondent's documentation and billing records at both COHCA and Aspen. The random sampling and full audit revealed discrepancies in Respondent's chart documentation, billing for services and travel time, and timekeeping records. (Those discrepancies are the basis of the allegations set forth in the First Amended Accusation, which are more fully discussed below.) Respondent was questioned about the discrepancies by COHCA and Aspen administrators. COHCA later issued to Respondent a Notice of Intent to Discharge dated April 28, 2004, indicating that COHCA intended to terminate his employment. Respondent was allowed to, and did, respond in writing to the charges contained in that notice.

9. By a Notice of Discharge dated May 17, 2004, Respondent was notified of his discharge from employment with COHCA. The stated basis for his termination was falsification of official medical records, falsification of timekeeping records, failure to follow supervisory directives and violation of policies and procedures. Respondent's effective date of termination was May 21, 2004. Respondent initiated an appeal from his termination, which is still pending.

Time Billed to Medi-Cal from *April 2002 to August 2003*

10. With regard to his duties for COHCA in 2002 and 2003, Respondent was expected to work 40 hours per week. Although he had previously been able to work up to ten hours per week of overtime, by 2002 and 2003 he and his colleagues were no longer allowed to work overtime unless they received permission beforehand or encountered an emergency situation. Overtime was rarely, if ever, approved. However, given the caseload they typically encountered in 2002 and 2003, Respondent and his colleagues were sometimes unable to perform all of their required duties in 40 hours per week. Therefore, sometimes Respondent and some of his colleagues simply worked more than 40 hours per week. Some, like Respondent, documented their additional work in a way that resulted in time greater than 40 hours per week being billed to Medi-Cal. Some simply wrote-off the additional work in ways that did not result in more than 40 hours being billed to Medi-Cal, even though that employee actually worked more than 40 hours in that particular week. Occasional staff memos and statements made during staff meetings by COHCA administrators stating that employees should not work more than 40 hours per week did not prevent the additional work from being performed. The involved employees felt their duties to their patients required them to spend whatever time was necessary, even if it meant working beyond 40 hours in a week.

11. When it was discovered that an employee had billed Medi-Cal more than 40 hours in a given week, COHCA administrators deleted the additional time from Medi-Cal bills, because they feared that Medi-Cal would disapprove any such amount, which could lead to charge-backs, audits, penalties or worse consequences.

12. COHCA employees such as Respondent were required to complete biweekly time sheets, which were internal pay roll forms used by the county for personnel reasons, such as determining whether an employee was entitled to full pay for that pay period, calculating vacation and sick-leave accrual and use, among other things. The time sheets were not submitted to Medi-Cal or otherwise directly used in the process of billing time to Medi-Cal. A time sheet showing more than 40 hours for a given week was returned to an employee for correction, unless overtime had been approved.

13. During the period of April 2002 through August 2003, Respondent submitted documentation to COHCA staff which represented the amount of time to be billed to Medi-Cal for his services. A comparison of Respondent's COHCA biweekly time sheets to his submitted documentation revealed that during this time period Respondent billed a total of 3,569 minutes (59.48 hours) in excess of the 40 hours per week that Respondent was required to work as a county employee, as follows: April 2002 (129 minutes over); May 2002 (297 minutes over); June 2002 (558 minutes over); July 2002 (69 minutes over); October 2002 (378 minutes over); November 2002 (137 minutes over); December 2002 (355 minutes over); January 2003 (382 minutes over); February 2003 (188 minutes over); March 2003 (134 minutes over); May 2003 (465 minutes over); June 2003 (168 minutes over); July 2003 (184 minutes over); and August 2003 (125 minutes over).

14. It was not clearly and convincingly established that Respondent falsely represented any amount of the time described immediately above. The COHCA administrators concluded that any billed amount for a given week greater than 40 hours constituted over-billing simply because Respondent was only supposed to work 40 hours in a given week. However, it was not established that Respondent's verification on his biweekly time sheets during this period meant that he only worked 40 hours in a week or 80 hours in a biweekly period. The time sheets that Respondent completed during this period simply verified that he worked at least 80 hours during that biweekly period, and was thus entitled to full pay. No evidence indicated that Respondent did not actually perform the services that were the subject of the above-described Medi-Cal billings, and Complainant did not attempt to make a connection between the amounts described immediately above and the events described below relating to documentation for three particular patients.

15. Due to the above-described COHCA policy regarding Medi-Cal billings for an employee totaling more than 40 hours in one week, once the above-described discrepancies were discovered between Respondent's biweekly time sheets and Medi-Cal bills submitted for his services, COHCA administrators decided to reimburse Medi-Cal $15,002.37, which corresponded to the 3,569 minutes of time described above.

Documentation for Patient Robert G.[1]

16. Robert G. was young male patient treated by Respondent. Respondent prescribed his psychiatric medications, monitored him and evaluated his progress on the medications. Robert G. was a patient of both COHCA and Aspen. Respondent often treated Robert G. on Thursdays at Aspen while performing his duties for Aspen. When at Aspen, Robert G. would often participate in what was referred to as "group process," in which he and other similarly situated patients would meet in a group with a therapist or health practitioner and engage in discussion. Services Robert G. received at Aspen were referred to as "day treatment." Robert G. also received medications at Aspen.

17. Respondent filled out a Psychiatric Medication Monitoring Record (PMMR) for Robert G. which indicated, among other things, that Respondent met with Robert G. at Aspen on July 25, 2003, which was a Friday, "and observed him in group process." The PMMR indicated that Respondent spent 129 minutes doing so.

18. It was not established that Respondent filled out a PMMR for Robert G. which indicated, among other things, that Respondent met with Robert G. for 139 minutes on August 8, 2003, "and observed him in group process." No such document was presented, and such an event was not the subject of the testimony of either COHCA administrator Patricia Rogers or Respondent.

19. Respondent filled out an Encounter Document and a Progress Note for Robert G. which, taken together, indicated that Respondent met with Robert G. at Aspen on August 22, 2003, which was a Friday. The Progress Note indicates, among other things, "Medication Follow Up at Day Tx (Aspen day treatment)" and contains Respondent's notations that "MD met with minor individually and in group reviewed his progress with day tx (treatment) staff observed interaction with peers and staff . . . ." Robert G. was present that day at Aspen to receive his medication.

20. Respondent filled out a PMMR for Robert G. which indicated, among other things, that Respondent met with Robert G. at Aspen on August 29, 2003, which was a Friday, for 79 minutes of face-to-face interaction.

21. Respondent filled out a PMMR for Robert G. which indicates, among other things, that Respondent met with Robert G. at Aspen on September 5, 2003, which was a Friday, for 78 face-to-face minutes and "observed minor in group process at day tx, he was alert . . . ." Respondent also submitted an Encounter Document for that date which indicated, among other things, that he spent 20 minutes for documentation time and 62 minutes for travel time. Robert G. was present at Aspen that day to receive his medication.

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[1] The last names of the three minor patients involved in this matter are omitted to protect their privacy.

22. Respondent filled out a PMMR for Robert G. which indicates, among other things, that Respondent met with Robert G. and his mother at Aspen on October 3, 2003, which was a Friday, for 68 minutes of face-to-face interaction. Among other things, the PMMR states "[Robert G.] is testing limits at home and school in day treatment has settled down."

23. Respondent submitted an Encounter Document for Robert G., which stated a date of service of October 6, 2003, which was a Friday. The Encounter Document indicated, among other things, that Respondent provided 68 minutes of medical services to Robert G., documentation time of 10 minutes, and 56 minutes for travel time. Respondent erroneously indicated the date of service was October 6, 2003, but in fact, the Encounter Document was meant to be the companion of the PMMR described above for October 3, 2003.

24. Respondent filled out an Encounter Document for Robert G., which indicates, among other things, that Respondent met with Robert G. at Aspen on October 24, 2003, which was a Friday, and provided medical services for 75 minutes, 10 minutes of documentation time, and 48 minutes of travel time. The PMMR Respondent filled out for this date also indicates a 75 minute face-to-face meeting with Robert G., with a notation indicating "met with [Robert G.] and observed him with his peers . . . ."

25. Records from Aspen and COHCA established that Robert G. was not present at Aspen on the dates in question; or that if he was there on a particular date to pick up medications, that he did not participate in group process or spend any appreciable time there. Those records, and the testimony of COHCA and Aspen administrators, therefore affirmatively established that Respondent did not provide the services that he claimed he performed in the above-described documents on the dates in question. Therefore, it was clearly and convincingly established that Respondent's above-described documentation for Robert G. was false because, among other things, Robert G. was not present at Aspen on the dates in question, Robert G. was not in group process those dates, and the services depicted in Respondent's documentation were therefore not rendered as claimed. With regard to the Encounter Document meant for October 3, 2003, and the PMMR dated October 24, 2003, Respondent also billed for documentation and travel time for services that did not occur.

26. Based on the above documentation discrepancies, COHCA reimbursed Medi-Cal $4,007.29 for 917 minutes of Respondent's time billed for Robert G.[2]

27. Respondent's testimony was not persuasive that he actually saw Robert G. on the dates in question and provided the services depicted in his documentation.

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[2] This amount included 139 minutes for the documentation of August 8, 2003, which was not established in this matter to have been falsely billed by Respondent.

28. Respondent's explanation was unconvincing regarding the discrepancies between the Aspen and COHCA records and his own documentation. Respondent testified that, on the dates in question, Robert G. visited him at Aspen solely related to his medications and not to participate in Aspen's formal day treatment program. Respondent further testified that he often established his own personal group process for Robert G. in his office, comprised of himself, Robert G. and a few other peers or relatives. However, Respondent did not corroborate his testimony. None of the Aspen employees who testified verified that Respondent had ever done so either. Moreover, the above-described Encounter Documents and PMMRs Respondent submitted for the dates in question do not sufficiently depict the unusual event of Respondent creating his own personal group process for Robert G. Respondent's testimony that he was unable to use billing conventions and CPT codes in filling out those documents to correctly depict those events was impeached by COHCA administrator Patricia Rogers. Respondent's credibility was further undermined by his prior inconsistent statements about this situation. For example, Respondent told an Aspen administrator who confronted him about these discrepancies that he (Respondent) may have possibly confused the patients; but he initially told Ms. Rogers of COHCA that he probably saw Robert G. on a Thursday and erroneously documented the services as having been rendered on a Friday. Finally, at no time did Respondent tell COHCA or Aspen administrators during their investigations that he formed his own personal group process for Robert G. outside the normal confines of the Aspen day treatment program.

29. The letter from Robert G.'s mother (which was admitted for the limited purpose of administrative hearsay) was given no weight, and therefore it failed to corroborate Respondent's testimony regarding his documentation for Robert G. The letter lacks specificity or detail to serve as sufficient corroboration. The letter does not state that Robert G. engaged in any form of group process or face-to-face interaction with Respondent on the dates in question. The letter is also wrong, in that it states that Robert G. allegedly visited Aspen on October 6, 2003, which Respondent testified was not a date that he saw Robert G.

Documentation for Patient Tyler B.

30. Tyler B. was another young male patient Respondent treated, under circumstances similar to Robert G. Respondent filled out a PMMR for Tyler B. which indicates, among other things, that Respondent "met with [Tyler B.] at Aspen and reviewed his progress with his group process staff" on Friday, June 20, 2003. The form indicates Respondent spent 136 minutes doing so.

31. Respondent filled out a PMMR for Friday, July 11, 2003, which indicates, among other things, that Respondent "met with [Tyler B.] and observed him in group process . . ." and "in group he was unable to sit still, needed a little redirection." The PMMR indicates Respondent spent 129 minutes doing so.

32. Respondent filled out a PMMR which indicates, among other things, that Respondent "met with [Tyler B.] in group process and reviewed his progress with day treatment staff . . ." on Friday, August 1, 2003. The form indicates Respondent spent 135 minutes doing so.

33. For the same reasons described above regarding Robert G., it was clearly and convincingly established that Respondent's above-described documentation for Tyler B. was false because, among other things, Tyler B. was not present at Aspen on the dates in question, he was not in group process on those dates, and the services were therefore not rendered as claimed.

34. Respondent's testimony was not persuasive that he actually saw and served Tyler B. at Aspen on the dates in question, for the same reasons discussed above regarding Robert G. Respondent's testimony was unpersuasive that he created his own group process for Tyler B. at Aspen on the dates in question, for the same reasons discussed above regarding Robert G. The letter from Tyler B.'s mother (which was admitted for the limited purpose of administrative hearsay) was given little weight and failed to corroborate Respondent's testimony regarding his treatment of Tyler B. For example, Tyler B.'s mother did not provide in her letter any dates or describe any details indicating that Tyler B. engaged in any form of group process or prolonged interaction with Respondent on the Fridays he would have visited Aspen.

35. On Thursday, August 28, 2003, Respondent met with Tyler B. at Aspen for day treatment. Aspen records document Tyler B.'s attendance there that day. On Friday, August 29, 2003, Tyler B. had a violent manic episode at his house. Two other COHCA employees handled the initial crisis call that came from Tyler B.'s sister. One COHCA employee, L.C.S.W. Kelley Ponce, consulted with Respondent telephonically regarding whether she could safely go to the family home to provide assistance. Tyler B. was ultimately hospitalized the next day, August 29, 2003. Respondent did not see Tyler B. on August 29, 2003, nor did Respondent travel to Aspen that day to see Tyler B.

36. Respondent filled out a PMMR which indicated, among other things, 78 face-to-face minutes of service with Tyler B. on August 29, 2003. On this form, Respondent indicated that he saw the patient "yesterday in day tx (treatment). was calm but today lost control. was hitting mother and sister." Respondent also noted that Tyler B. "needed to be hospitalized . . . ." In a box on that form used to indicate the "Date of Service," Respondent had initially written "8-28-03," but he changed the date by replacing the "28" with a "29," indicating that the date of service was August 29, 2003. Respondent also filled out an Encounter Document with a date of service of August 29, 2003, for medical services of 78 minutes and travel time of 62 minutes. A review of the documents in question would lead one to erroneously conclude that Respondent spent 78 minutes with Tyler B. on August 29th, the day of his hospitalization, in addition to having seen him the previous day at Aspen.

37. Respondent's documentation for August 29, 2003, was false because, among other things, Tyler B. was not present at Aspen for a visit with Respondent on that date, Respondent did not engage in any travel with regard to Tyler B. on that date, and therefore the services and travel time as claimed were not rendered. Respondent's only activity related to Tyler B. on August 29, 2003, was his telephone consultation with the COHCA employee(s).

38. Respondent's explanation was not credible regarding his erroneous documentation of services to Tyler B. on August 29, 2003, as follows:

A. Respondent testified that he simply "collapsed" his services rendered on both days to the single date of August 29th. However, Respondent knew from his years of experience and copious training with COHCA that doing so was not appropriate. Respondent also knew, or should have known, that it was not appropriate to make a date change on a medical document by simply writing a new date over the initial date. Respondent's explanation was also problematic because he usually saw Tyler B. on Thursdays at Aspen when he was not working for the county.

B. Respondent testified unpersuasively that the travel time he billed for the 29th was appropriate because he had in fact traveled to Aspen to see Tyler B. on August 29th, not knowing at the time that Tyler B. had already been taken to the hospital. Since Respondent had already spoken to the COHCA employee over the telephone about the situation, it is not readily apparent from Respondent's testimony why he would have assumed Tyler B. had been taken to the Aspen clinic instead of to the hospital. In any event, Respondent put nothing on the PMMR for this date that could be construed as indicating that Tyler B. was not at the clinic on the 29th when Respondent allegedly went there to see him. Moreover, when initially confronted about this discrepancy during the COHCA investigation, Respondent admitted that he did not see Tyler B. that day and stated that he only spoke with the COHCA employee and Tyler B.'s mother over the telephone; he offered no explanation for billing travel time under those circumstances. After receiving COHCA's Notice of Intent to Discharge, which specified the basis of this charge and included supporting documentation, Respondent explained this discrepancy was caused by collapsing services from two days on a single progress note, but he stated nothing about traveling to Aspen on the 29th or that Tyler B. was not there.

39. Based on the above documentation discrepancies, COHCA reimbursed Medi-Cal $2,340.76 for 540 minutes of Respondent's time billed for Tyler B.

Documentation for Patient Travis M.

40. Travis M. was another young male patient Respondent treated. Respondent filled out documentation in which he billed 52 minutes for a visit with Travis M. at the Raymond Temple School clinic on September 29, 2003. In the PMMR he completed for that visit, Respondent stated the 52 minutes were spent "face-to-face," including meeting with Travis M. "and reviewing his progress with his aunt . . . and primary therapist (L.C.S.W.

Evelyn Murtaugh). In fact, Respondent spent only 5 minutes on Travis M. that day. He briefly consulted with Ms. Murtaugh about Travis M., in the middle of Ms. Murtaugh's therapy session with Travis M. Respondent did not meet with Travis M. that day. Respondent did not meet with Travis M.'s aunt either, because she did not go to the clinic that day. Respondent's documentation was false, because Respondent did not see Travis M. for 52 minutes and the services were therefore not rendered as claimed.

41. Respondent's testimony was not persuasive that he actually met with Travis M. for 52 minutes on September 29, 2003, for the following reasons. Evelyn Murtaugh credibly testified that Respondent could not have met with Travis M. before her therapy session, because she saw Travis M. after he got out of school and time would not have permitted him to also meet with Respondent for that long before her therapy session with him. Also, Ms. Murtaugh credibly testified that the clinic was so small that she would have known when Travis M. had arrived and/or interacted with Respondent that day; Ms. Murtaugh was sure that Respondent had not done so. Respondent could not have met with Travis M. after Ms. Murtaugh's therapy session either, because after her session Ms. Murtaugh walked Travis M. outside to his brother, who was waiting in his car to take Travis M. home.

42. Respondent's prior inconsistent statements about this event further eroded his credibility. For example, Respondent testified that he had actually spoken with Travis M.'s aunt over the phone; but his notation on the PMMR indicates that he had spoken with her face-to-face that day, which did not occur. When confronted about this event during COHCA's investigation, Respondent initially stated that he had met with Travis M. after Ms. Murtaugh's therapy session. When he was advised that Ms. Murtaugh had taken Travis M. out of the clinic after her therapy session, Respondent stated (in his written response to the Notice of Intent to Discharge) only that he met Travis M. "sometimes before or after his meeting with primary therapist Ms. Murtaugh."

43. Based on the above documentation discrepancy, COHCA reimbursed Medi-Cal $292.79 for 67 minutes of Respondent's time billed for Travis M.

Contract Work with Aspen Day Treatment Program

44. From 2001 through March 2004, Respondent worked as a contract psychiatrist for Aspen. Respondent did his work for Aspen at three different locations. He worked in that capacity for Aspen every Thursday, which was his off-day at COHCA. Respondent occasionally did Aspen-related work on days other than Thursday, mainly at nights and on weekends. His usual schedule on Thursdays at Aspen was from 8:00 a.m. to 6:30 or 7:00 p.m., or later, depending on his caseload and/or any emergencies. Because Respondent was required to submit to Aspen his documentation and progress notes within 24 hours of seeing a patient, he sometimes would finish documenting his Aspen work for a given day at home after he left the clinic.

45. Respondent was paid hourly for his work at Aspen. He submitted weekly billing documents to Aspen staff, who would prepare biweekly invoices that were submitted to Respondent's Aspen supervisor for payment approval. COHCA monitored the Aspen contract for Respondent's services and many of the patients he saw at Aspen were also patients of COHCA.

46. Pursuant to written agreements Respondent executed with Aspen, Respondent was expected to work approximately 16-20 hours per week on and after April 1, 2001. Beginning on and after July 1, 2003, the parties agreed in a work order that Respondent would work a maximum of 16 hours per week, which amount was renewed by subsequent work orders dated August 1, 2003 and November 1, 2003.

47. As a result of COHCA's investigation of Respondent's billing and documentation practices, Respondent's invoices submitted to Aspen were also audited. A review of that documentation for the period of May 2003 through August 2003 revealed that several times Respondent billed Aspen for as many as 13.50 to 21.05 hours in a single day. COHCA administrators were suspicious that Respondent could have performed that many hours of service in one day and concluded that he over-billed those amounts.[3]

48. With respect to Respondent's Aspen invoices for the time period of May 1, 2003, through June 30, 2003, it was not clearly and convincingly established that Respondent falsely stated the amount of time in which he performed his services for Aspen or otherwise over-billed Aspen for his time. Respondent submitted invoices during that time period indicating that he sometimes worked between 16.55 to 18.45 hours on a given day (or a 24-hour time period). The evidence presented failed to meet the clear and convincing standard necessary to establish that Respondent did not perform the services claimed in those invoices. Unlike the situations discussed above regarding Robert G., Tyler B. and Travis M., there is no affirmative probative evidence indicating that Respondent did not provide these services. On the other hand, there was some circumstantial evidence showing that Respondent could have worked that many hours in one day. For example, Respondent was under contract during that time to work between 16-20 hours per week, and Respondent's supervisor at Aspen knew that he usually performed the bulk of his work for any given week on one day, i.e. Thursday. In fact, Respondent's supervisor at Aspen, Katharine Wells, testified that she approved Respondent's invoices in question and had no reason to believe at the time that Respondent did not do the work indicated.

49. With respect to Respondent's Aspen invoices for the time period of July 1, 2003, through August 29, 2003 (other than for July 16-31, 2003, discussed immediately below), it was not clearly and convincingly established that Respondent falsely stated the amount of time in which he performed his services for Aspen or otherwise over-billed Aspen for his time. The majority of invoices submitted to Aspen by Respondent during this time

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[3] Incidentally, the only specific reference to any Aspen invoice contained in either COHCA's Notice of Intent to Discharge, or the First Amended Accusation, is the 21.05 hours that Respondent billed for his services for July 17, 2003, discussed below.

stated that Respondent worked between 13.50 to 15.50 hours on most Thursdays, which was below the maximum amount of 16 hours he was to perform per week, according to the work order he executed on July 1, 2003. The reasoning discussed immediately above has even greater application to these invoices, given the lower number of hours billed per day.

50. Respondent's Aspen invoice for July 16-31, 2003, stated that he performed 21.05 hours of service on July 17, 2003. This invoice was prepared by another person at Aspen based on billing materials submitted by Respondent for use in preparing the invoice.

51. Respondent over-billed Aspen for his time on July 17, 2003, and Respondent falsely stated in his billing materials that he performed 21.05 hours of billable service on that date. Unlike his earlier invoices, Respondent by this time was limited to 16 hours of work per week for Aspen. Therefore, on its face, billing more than 16 hours on one particular day was questionable; that amount was also inconsistent with the other invoices Respondent submitted during this time period, which were at or below 16 hours for a given week. Patricia Rogers of COHCA testified that, in her experience, Respondent could not have performed 21 hours of billable service in one day. Respondent's supervisor at Aspen, Ms. Wells, testified that a bill for 21.05 hours in one day was "probably unrealistic." Unlike the invoices discussed above, there is no circumstantial evidence indicating that Respondent could have plausibly performed that many hours of billable service in one day. While 16-18 hours of billable service is viewed as the upper-most limit of service Respondent could have performed in one day, 21 hours stretches far past that limit. For Respondent to have performed 21 hours of service in one day, he would have had to work *non-stop* from 8:00 a.m. on July 17th to 5:00 a.m. the following morning, without eating, sleeping, interacting with his wife or children (Respondent testified that he spent many hours that night at home doing patient documentation), and commuting to and from work and home. Under these circumstances, the clear and convincing standard is met, even in the absence of affirmative evidence indicating that Respondent did not perform 21 hours of billable service on July 17, 2003.

52. Respondent eliminated the possibility that his invoice for 21.05 hours of service in one day was in error when he testified that he in fact worked that many hours on July 17, 2003. Respondent's testimony was not persuasive. He offered no specific, credible evidence indicating that he in fact worked that many hours on that day. It is reasonable to expect one who had performed that many billable hours in a single day to be able to remember details of that endeavor. Respondent provided none in his testimony, not even the times he began and completed his work.

53. It was not clearly and convincingly established that Aspen reimbursed COHCA or Medi-Cal due to Respondent's above-described invoices submitted to Aspen.[4]

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[4] Although there was some testimony concerning Aspen billings being "backed out" relative to Medi-Cal, it was not clear if that action was taken because of these invoices or other documentation discrepancies in Respondent's charts later discovered by Aspen but not made a part of the First Amended Accusation.

54. Respondent was required to keep his work on Thursdays at Aspen separate from that performed while working for COHCA. However, sometimes a clear line of separation was not always possible. As discussed above, many of those Respondent treated were clients of both agencies. Some clients Respondent saw while working for the county preferred to be seen at Aspen on some occasions. Sometimes Respondent was pressed into county business while at Aspen on Thursdays performing his Aspen duties.

55. It was not clearly and convincingly established that Respondent saw patients on Thursdays while working for Aspen but documented and/or submitted bills indicating that activity occurred on Fridays while he was working for COHCA.[5]

Standard of Care Regarding Medical Documentation

56. It was established by the testimony of Complainant's expert witness, Dr. Mark Kalish, that the standard of care is for physicians to accurately state in patient documentation the dates of treatment and the treatment that was provided.

57. Respondent committed repeated negligent acts with regard to patients Robert G., Tyler B., and Travis M., in that, on the occasions noted above, Respondent departed from the standard of care when he wrote progress notes that falsely indicated that he had examined those patients on a particular date when, in fact, he had not.

58. Respondent was also grossly negligent with regard to those progress notes for Robert G., Tyler B., and Travis M., which falsely indicated that he had examined those patients on a particular date when, in fact, he had not. Respondent's departure from the standard of care was extreme, given the number of false documents in question and the fact that his progress notes were done in a clinical setting where other health care providers relied on their accuracy in rendering their own treatment to those patients.

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[5] This allegation of the First Amended Accusation was based on the supposition of Patricia Rogers from statements Respondent made to her during COHCA's investigation to the effect that some of the documentation discrepancies may have been due to his having seen patients at Aspen on Thursdays but erroneously documenting the dates of service as the following Fridays. However, Respondent did not testify during the hearing that such had occurred. In addition, Ms. Rogers' testimony on this issue was too general to clearly and convincingly establish that Respondent had in fact engaged in this activity. For instance, with regard to Respondent's August 29, 2003 documentation for Tyler B., it was not clearly and convincingly established that Respondent had treated Tyler B. on August 28th on behalf of Aspen, only to bill that work to COHCA (with a stated date of service of August 29th). The findings above regarding the Tyler B. documentation for August 29th are limited only to establishing that Respondent falsely documented services as having been rendered on August 29th, not that Respondent also had performed those services on behalf of Aspen the previous day. As found above, simply because Respondent saw a patient on a Thursday at Aspen did not necessarily mean his treatment was not on county time.

Evidence in Mitigation and Aggravation

59. Mitigating evidence. There is no Board record of prior disciplinary action against Respondent's certificate. Respondent was proven to be a caring and otherwise competent practitioner, as corroborated by the testimony of his supervisors and colleagues at COHCA and Aspen. Respondent was well-liked by his patients and co-workers. He took on difficult cases for COHCA and Aspen and did a good job. No evidence was presented of any other personnel actions taken against Respondent by COHCA or Aspen, other than as described above. In fact, Respondent consistently received very favorable yearly employment evaluations by his supervisors at COHCA, before the events described above. Aspen never sought to recover from Respondent any funds paid to him from his invoices that are involved in this matter.

60. Aggravating evidence. Respondent has not accepted any responsibility for his misconduct. He has continuously denied engaging in any of the above-described misconduct. He has admitted to only one mistake, related to his allegedly "collapsing" services rendered over two dates into one progress note (Tyler B.'s PMMR for August 29, 2003). But, as found above, Respondent's testimony was not persuasive that his "mistake" was the result of inadvertence, as opposed to intentional misconduct. COHCA refunded Medi-Cal approximately $6,500.00 due to Respondent's misconduct established above.

Respondent's Defenses

61. Respondent offered a variety of excuses for some of his actions, none of which were proven to be a satisfactory explanation for his misconduct. For example:

A. Respondent during his testimony suggested that COHCA administrators may have decided to fire him in retaliation for his having joined a grievance against the county for increasing the number of billable units of work that he and his colleagues were expected to perform each year. Yet, it was not established that COHCA administrators took any action against him for reasons other than the above-described documentation discrepancies. For example, Respondent consistently received very favorable reviews by his supervisors at COHCA during the times in question.

B. It was not established that Respondent's busy work schedule caused him to engage in any of his misconduct. In fact, Respondent did not testify that being busy caused him to make any false document entries. In any event, Respondent had a hand in his own busy schedule, as it was his decision to work for Aspen and the private practice in Burbank, in addition to his full-time job for the county.

C. Respondent began experiencing headaches and pain in his arm, for which he ultimately sought treatment from a physician. Yet, it was not established how those medical conditions caused him to make documentation errors or otherwise engage in his misconduct. In any event, most of the treatment Respondent received for those ailments was well after he had committed his misconduct.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. The burden of proof is on Complainant, and the standard of proof is clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 855-856.) (Factual Findings 1-2.)

Cause for Discipline

2. FIRST CAUSE FOR DISCIPLINE (Acts of Dishonesty or Corruption). Respondent is subject to disciplinary action under Business and Professions Code sections 2227 and 2234,[6] as defined by section 2234, subdivision (e), in that it was clearly and convincingly established that Respondent committed acts of dishonesty or corruption. With regard to patients Robert G., Tyler B. and Travis M., Respondent prepared and submitted false documentation for services not actually rendered, and billed for travel time which did not occur. (Factual Findings 16, 17, and 19-43.) With regard to the Aspen Day Treatment Center, Respondent submitted one invoice that falsely stated the amount of time in which he performed his services. (Factual Findings 44-47 and 50-52.) The false documentation in question was committed in the course of Respondent's conduct as a licensed medical practitioner, and therefore was substantially related to the qualifications, duties and functions of a physician and surgeon.

3. SECOND CAUSE FOR DISCIPLINE (General Unprofessional Conduct). Respondent is subject to disciplinary action under sections 2227 and 2234, in that it was clearly and convincingly established that Respondent engaged in general unprofessional conduct. General unprofessional conduct has been defined as conduct which demonstrates an unfitness to practice medicine, conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming to a member of the medical profession in good standing. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.) As discussed in further detail below, a failure to properly document and/or maintain billing and medical records can support a claim for unprofessional conduct under section 2234. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1053.) In this case, Respondent, on many occasions relative to three different patients (Robert G., Tyler B. and Travis M.), prepared and submitted false documentation for services not actually rendered, and billed for travel time which did not occur. In addition, Respondent submitted to the Aspen Day Treatment Center one invoice that falsely stated the amount of time in which he performed his services. Such activity demonstrates conduct unbecoming of a member of the medical profession in good standing and therefore is deemed to be generally unprofessional conduct. (Factual Findings 16, 17, 19-43, 44-47 and 50-52.)

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[6] All further statutory references are to the Business and Professions Code unless otherwise noted.

4. THIRD CAUSE FOR DISCIPLINE (Knowingly Creating or Signing False Documents Related to the Practice of Medicine). Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2261, in that it was clearly and convincingly established that Respondent knowingly created false medical records. With regard to patients Robert G., Tyler B. and Travis M., Respondent prepared and submitted false documentation for services not actually rendered, billed for travel time which did not occur, and improperly billed for documentation time associated with creating false records. With regard to the Aspen Day Treatment Center, Respondent submitted one invoice that falsely stated the amount of time in which he performed his services. (Factual Findings 16, 17, 19-43, 44-47 and 50-52.)

5. FOURTH CAUSE FOR DISCIPLINE (Creating False Medical Records). Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2262, in that it was clearly and convincingly established that Respondent created false medical records with fraudulent intent. With regard to patients Robert G., Tyler B. and Travis M., Respondent documented services rendered which were not actually performed, improperly billed for documentation time associated with creating false records, and billed for improper travel time. With regard to the Aspen Day Treatment Center, Respondent submitted one invoice that falsely stated the amount of time in which he performed his services. (Factual Findings 16, 17, 19-43, 44-47 and 50-52.)

6. FIFTH CAUSE FOR DISCIPLINE (Failure to Maintain Accurate Records). Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, in that it was clearly and convincingly established that Respondent failed to maintain adequate and accurate medical and billing records. With regard to patients Robert G., Tyler B. and Travis M., Respondent inaccurately documented services as having been rendered which were not performed. With regard to the Aspen Day Treatment Center, Respondent submitted one invoice that falsely stated the amount of time in which he performed his services. (Factual Findings 16, 17, 19-43, 44-47 and 50-52.)

7. SIXTH CAUSE FOR DISCIPLINE (Gross Negligence). Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), in that it was clearly and convincingly established that Respondent was grossly negligent by writing several progress notes falsely indicating that he had examined patients Robert G., Tyler B. and Travis M. on many occasions when, in fact, he had not. (Factual Findings 16, 17, 19-43, and 56-58.)

Respondent's argument is unpersuasive that medical record "deficiencies" cannot support a finding of gross negligence, as opposed to more standard claims directly relating to patient quality of care issues (such as malpractice). Section 2234, subdivision (b), is quite broad on its face, in a way inconsistent with Respondent's argument. In addition, Respondent cites no case authority holding that documentation deficiencies cannot form the basis of a violation of section 2234. In *Kearl v. Board of Medical Quality Assurance, supra,* 189 Cal.App.3d at 1053, the court stated that section 2234 "does not limit gross negligence or unprofessional conduct to the actual treatment of a patient – as opposed to administrative

work . . . ." The court in *Kearl* went on to conclude that the physician in question had committed gross negligence by failing to record a patient's vital signs every five minutes. The *Kearl* case therefore indicates that documentation deficiencies can be the basis of discipline under section 2234.

8. SEVENTH CAUSE FOR DISCIPLINE (Repeated Negligent Acts). Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), in that it was clearly and convincingly established that Respondent committed repeated negligent acts by writing progress notes falsely indicating that he had examined patients Robert G., Tyler B. and Travis M. on many occasions when, in fact, he had not. (Factual Findings 16, 17, 19-43, and 56-58.) Respondent's argument about the propriety of this charge relative to documentation deficiencies is rejected for the same reason described immediately above.

Disposition of Discipline

9. Section 2229, subdivision (a), provides that "[p]rotection of the public shall be the highest priority . . . " for the Board in exercising disciplinary authority. However, section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees.

In determining the disposition of this matter, the ALJ referred to the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (Guidelines) [9th edition, rev. 2003]. After weighing all the circumstances of this case, the ALJ concludes that revocation would be overly harsh, and that instead minimum discipline is warranted for several reasons. For example, Respondent has no prior disciplinary history with the Board after 15 years of licensure. While the false chart entries in three patient files presented the potential for harm, no actual harm to those patients was proven. Although Respondent's employer COHCA reimbursed Medi-Cal due to Respondent's misconduct, it was not established that the county's relationship with Medi-Cal was otherwise harmed. Respondent's false billing involved lower amounts. COHCA reimbursed approximately $6,500.00 to Medi-Cal as a result of Respondent's established misconduct, but Respondent did not directly benefit financially from that activity. It was established that Respondent over-billed Aspen on one occasion; while Respondent financially benefited from that transaction, the amount in question was relatively low. Overall, the mitigating evidence in this case outweighs the aggravating evidence. More importantly, it was established that Respondent's career is very much worth salvaging. Respondent is a caring, dedicated and competent health care practitioner, who is well-respected and liked by many of his colleagues and patients. The below disciplinary order is therefore calculated to facilitate Respondent's rehabilitation from his misconduct established in this case, while at the same time including terms and conditions meant to protect the public. (Factual Findings 1-61.)

Seven different causes for discipline were established in this case. The Guidelines suggest varying levels of minimum discipline for each of those seven categories. Yet, the real gravity of this case is generated by the category related to Respondent's dishonesty arising from or occurring during patient care, treatment, management or billing (Guidelines, page 31). The minimum discipline suggested for that violation is the template used for the below disciplinary order, with the addition of some coursework, and some downward departures made to facilitate Respondent's rehabilitation. For example, a five year period of probation is more likely to facilitate rehabilitation than a seven year period, mainly because Respondent can accomplish the other terms and conditions in that period. Because Respondent has yet to admit his misconduct or show any remorse, a suspension is warranted to facilitate that process. Therefore, the one year suspension period suggested by the Guidelines appears warranted. Because Respondent has proven his technical skill and subject matter knowledge, requiring him to undergo oral or written examinations is not warranted. Requiring him to undergo psychiatric or medical evaluations also seems unwarranted. A billing monitor is warranted, but that level of oversight and supervision obviates the need for prohibiting Respondent from engaging in solo practice or any kind of practice restriction.

ORDER

Physician's and Surgeon's Certificate Number A 51207 issued to Respondent John N.S. Rajaratnam, M.D. is revoked pursuant to Legal Conclusions 2-8, separately and for all of them. However, revocation is stayed and Respondent is placed on probation for five years upon the following terms and conditions.

1. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine for one year beginning the sixteenth (16th) day after the effective date of this decision.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation. If Respondent is unable to enroll in such a course due to his suspension, that shall be taken into consideration in computing the time necessary to complete this requirement.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Ethics Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation. If Respondent is unable to enroll in such a course due to his suspension, that shall be taken into consideration in computing the time necessary to complete this requirement.

An ethics course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Monitoring - Billing

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as a billing monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's billing shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor(s) shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of billing, and whether respondent is billing appropriately.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

5. Notification

Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent.

Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. **Supervision of Physician Assistants**

During probation, respondent is prohibited from supervising physician assistants.

7. **Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. **Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. **Probation Unit Compliance**

Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

10. **Interview with the Division or its Designee**

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

11. Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

12. Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non- practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

13. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

14. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: November 9, 2007

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Office of Administrative Hearings

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: JOHN N.S. RAJARATNAM, M.D. 23509 Ridgeline Road Diamond Bar, CA 91765 Physician's and Surgeon's Certificate No. A 51207, Respondent.	Case No. 04-2004-163478 OAH No. 2007010013 **FIRST AMENDED ACCUSATION** (Cal. Gov. Code, § 11507.)

Complainant alleges:

PARTIES

1. David T. Thornton (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, and not otherwise.

2. On or about September 22, 1992, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 51207 to John N.S. Rajaratnam, M.D. (hereinafter "Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2008, unless renewed.

JURISDICTION

3. This First Amended Accusation, which supercedes the original Accusation filed in this matter on November 14, 2006, is brought before the Division of Medical Quality (Division) for the Medical Board of California, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the

licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . ."

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

". . ."

6. Unprofessional conduct under California Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.[1/]

7. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

8. Section 2262 of the Code states:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct . . ."

9. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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1. *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.

FIRST CAUSE FOR DISCIPLINE

(Acts of Dishonesty or Corruption)

10. Respondent is subject to disciplinary action under section 2227 and 2234, as defined by section 2234, subdivision (e), of the Code in that he, among other things, committed an act or acts of dishonesty or corruption by preparing and submitting false documentation for services not actually rendered, billing for travel time which did not occur, and billing Medi-Cal and the Aspen Day Treatment Center for excessive hours. The circumstances are as follows:

11. On or around July 1994, Respondent was retained with the County of Orange Health Care Agency (HCA) as a contract Psychiatrist. He was hired as a regular employee of the HCA on August 16, 1996 as a Community Mental Health Psychiatrist. Respondent's duties as a Community Mental Health Psychiatrist generally included, but were not limited to, assessing, diagnosing and administering treatment to patients; providing psychiatric medications when appropriate; developing medication plans; providing crisis intervention and emergency medications when appropriate; and preparing comprehensive, concise and accurate reports and records.

12. As an employee of the HCA, Respondent was well aware of, or should have been aware of, the requirement to among other things: conform to the code of ethics and standards for the medical profession; keep separate any work done for the HCA and any contract employers, such as the Aspen Day Treatment Center; take reasonable precautions to ensure that documentation relating to patient treatment and billing was accurate and in compliance with any and all applicable laws; ensure that no false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind were submitted; and to bill only for services actually rendered and fully documented.

13. On or about August 4, 2003, HCA's Office of Compliance received an anonymous call alleging, among other things, Respondent was inappropriately billing for services which were not provided. The anonymous call prompted a random sample review of Respondent's documentation and billing records. The random sampling revealed discrepancies in, but not limited to, the amount of time billed for services and travel time and whether services were actually provided as set forth in documentation prepared by Respondent. Based on the results of the random sampling, a full audit was conducted of Respondent's documentation and billing records. The random

sampling and full audit revealed numerous discrepancies in Respondent's chart documentation, billing for services and travel time, and time keeping records as set forth more fully herein.

14. During Respondent's investigatory interview of December 8, 2003 with HCA personnel, Respondent confirmed he was aware of and understood he could not bill for more hours than what was actually worked. Respondent further acknowledged he understood that any overtime needed to be approved by his service chief.

15. On or about April 28, 2004, Respondent was given a Notice of Intent to Discharge from his employment with the HCA. The basis for his termination was falsification of official medical records, falsification of timekeeping records, failure to follow supervisory directives and violation of policies and procedures. Respondent's effective date of termination was May 21, 2004.

Irregularities with Time Billed to Medi-Cal

16. During the period of April 2002 to August 2003, Respondent submitted documentation which falsely represented the amount of time to be billed to Medi-Cal which has required, or which will require, HCA to reimburse Medi-Cal for excessive billing based on the documentation submitted by Respondent. Specifically, a comparison of Respondent's time-sheets and case documentation with his billing for services established that Respondent over-billed a total of 3,569 minutes (59.48 hours) in excess of the time Respondent reported as actually having worked. This discrepancy required, or will require, the HCA to reimburse Medi-Cal in the amount of $15,002.37 for the following time which was over-billed: April 2002 (129 minutes over-billed); May 2002 (297 minutes over-billed); June 2002 (558 minutes over-billed); July 2002 (69 minutes over-billed); October 2002 (378 minutes over-billed); November 2002 (137 minutes over-billed); December 2002 (355 minutes over-billed); January 2003 (382 minutes over-billed); February 2003 (188 minutes over-billed); March 2003 (134 minutes over-billed); May 2003 (465 minutes over-billed); June 2003 (168 minutes over-billed); July 2003 (184 minutes over-billed); and August 2003 (125 minutes over-billed).

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False Documentation for Services Not Performed

17. The previously mentioned random sampling and subsequent full audit of records pertaining to Respondent's treatment of certain patients established that Respondent falsified records which were directly or indirectly related to his treatment of certain patients while employed by HCA. In general, Respondent falsely represented having face-to-face sessions which did not take place and then billed for his false documentation, travel time, and for services which did not occur as discussed more fully below.

False Documentation for Patient R.G.

18. Respondent filled out a Psychiatric Medication Monitoring Record for Patient R.G. which indicated, among other things, Respondent met with Patient R.G. on or about July 25, 2003 "and observed him in group process." The form indicated 129 minutes. The documentation was false and constituted dishonesty or corruption because, among other things, Patient R.G. did not attend day treatment, was not in group process on this date, and the services were not rendered as claimed.

19. Respondent filled out a Psychiatric Medication Monitoring Record for Patient R.G. which indicated, among other things, Respondent met with Patient R.G. for 139 minutes on or about August 8, 2003 "and observed him in group process." The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient R.G. did not attend day treatment, was not in group process on this date, and the services were not rendered as claimed.

20. Respondent filled out a Progress Note for Patient R.G. which indicated, among other things, Respondent met with Patient R.G. on or about August 22, 2003. The Progress Note for the same date indicates, among other things, "Medication Follow Up at Day Tx" and contains Respondent's notations that "MD met with minor individually and in group reviewed his progress with day tx staff observed interaction with peers and staff . . ." The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient R.G. was not present at day treatment on this date, was not present for any group setting or any individual meeting, and the services were not rendered as claimed.

21. Respondent filled out a Psychiatric Medication Monitoring form for Patient R.G. which indicated, among other things, Respondent met with Patient R.G. on or about August 29, 2003 for 79 face-to-face minutes. The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient R.G. was not at day treatment on this date, was not in group process on this date for any individual meeting, and the services were not rendered as claimed.

22. Respondent filled out a Psychiatric Medication Monitoring form for Patient R.G. which indicates, among other things, Respondent met with Patient R.G. on or about September 5, 2003 for 78 face-to-face minutes and ". . . [o]bserved minor in group process at day tx, he was alert . . ." Respondent also submitted an Encounter Document which indicated, among other things, 20 minutes for documentation time and 62 minutes for travel time. The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient R.G. was not present at day treatment on this date, was not present for group process, and the services were not rendered as claimed. Also, Respondent billed for his false and dishonest documentation and for travel time for a face-to-face meeting which did not occur.

23. Respondent filled out a Psychiatric Medication Monitoring form for Patient R.G. which indicates, among other things, Respondent met with Patient R.G. and his mother on or about October 3, 2003 for 68 face-to-face minutes. Among other things, the Psychiatric Medication Monitoring form states "[Patient R.G.] is testing limits at home and school in day treatment has settled down." The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient R.G. was not present at day treatment on this date, was not present for any face-to-face meeting on this date, and the services were not rendered as claimed.

24. Respondent submitted an Encounter Document for Patient R.G. for October 6, 2003 which indicated, among other things, 68 minutes for providing medical services for Patient R.G., documentation time of 10 minutes, and 56 minutes for travel time. The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient R.G. was not present for any group meeting on this date and the services were not rendered as

claimed. Also, Respondent billed for his false and dishonest documentation, and for travel time for a face-to-face meeting which did not occur.

25. Respondent filled out an Encounter document which indicates, among other things, he provided medical services for 75 minutes, 10 minutes of documentation time, and 48 minutes of travel time. The Psychiatric Medication Monitoring Form indicates 75 minute face-to-face meeting with Patient R.G. on or about October 24, 2003 with a notation indicating "met with [Patient R.G.] and observed him with his peers . . ." The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient R.G. was not present at day treatment on this date and the services were not rendered as claimed. Also, Respondent billed for his false and dishonest documentation and for travel time for a face-to-face meeting which did not occur.

False Documentation for Patient T.B.

26. Respondent filled out a Psychiatric Medication Monitoring form which indicates, among other things, that Respondent "met with [Patient T.B.] at Aspen day treatment and reviewed his progress with his group process staff" on or about June 20, 2003. The form indicates 136 minutes. The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient T.B. was not present for day treatment on this date and the services were not rendered as claimed..

27. Respondent filled out a Psychiatric Medication Monitoring form on or about July 11, 2003 which indicates, among other things, that Respondent "met with [Patient T.B.] and observed him in group process . . ." and "in group he was unable to sit still, needed a little redirection." The form indicates 129 minutes. The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient T.B. was not present for day treatment on this date, was not present for group process, and the services were not rendered as claimed.

28. Respondent filled out a Psychiatric Medication Monitoring form which indicates, among other things, that Respondent "met with [Patient T.B.] in group process and reviewed his progress with day treatment staff . . ." on or about August 1, 2003. The form indicates

135 minutes. The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient T.B. was not present for day treatment on this date, was not present for group process, and the services were not rendered as claimed.

29. Respondent filled out a Psychiatric Medication Monitoring form which indicated, among other things, 78 face-to-face minutes on or about August 29, 2003. Respondent also filled out an Encounter Document with a date of service of August 29, 2003 for Patient T.B. for medical services of 78 minutes and travel time of 62 minutes. The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient T.B. was not present for any visit of 78 face-to-face minutes on or about August 29, 2003 and the services and travel time as claimed were not rendered or did not take place.

False Documentation for Patient T.M.

30. Respondent filled out documentation in which he billed for 52 minutes for a visit with Patient T.M. on or about September 29, 2003 which lasted only 5 minutes. The documentation was false and constituted an act or acts of dishonesty or corruption because, among other things, Patient T.M. was only seen on this date by Respondent for 5 minutes, not for 52 minutes, and the services were not rendered as claimed.

Over-billing and Improper Billing for Contract Work with Aspen Day Treatment Center

31. Respondent was employed by HCA to work on Mondays, Tuesdays, Wednesdays and Fridays. On Thursdays, Respondent worked as a contract Psychiatrist with the Aspen Treatment Center. HCA monitored the Aspen Treatment Center contract for Respondent's work as a contract Psychiatrist for the Aspen Treatment Center on Thursdays and also indirectly paid Respondent's salary for his contract Psychiatrist services for the Aspen Day Treatment Center for his work on Thursdays.

32. A review of documentation revealed that from May through August 2003, Respondent billed the Aspen Day Treatment Center, for whom Respondent worked on Thursdays as a contract Psychiatrist, as much as twenty-one hours in a day.

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33. Respondent was required to keep his work on Thursdays at Aspen Day Treatment Center separate from that performed while working for the County. To the extent Respondent saw patients on Thursdays while working for Aspen Day Treatment Center, which he later documented as having occurred on Fridays while he was working for the County, he improperly documented and billed services through the County for his Thursday work at Aspen which was then passed on to Medi-Cal.

SECOND CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

34. Respondent is further subject to disciplinary action under sections 2227 and 2234 of the Code in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly described hereinafter:

35. Paragraphs 10 through 33 , above, are incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Knowingly Creating or Signing False Documents Related to the Practice of Medicine)

36. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2261 of the Code, in that Respondent knowingly created false medical records with fraudulent intent by documenting services rendered which were not actually performed, improperly billed for "documentation time" associated with creating false records, billed for improper travel time, falsely represented the amount of time worked in documents submitted for billing to Medi-Cal, and falsely represented the amount of time worked at Aspen Day Treatment Center. The circumstances are as follows:

37. Paragraphs 10 through 33 are incorporated by reference and realleged as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(Creation of Fraudulent Medical Records)

38. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2262 of the Code, in that Respondent prepared and submitted false medical records with fraudulent intent by documenting services rendered which were not actually performed, improperly billed for "documentation time" associated with creating false records, billed for improper travel time, falsely represented the amount of time worked in documents submitted for billing to Medi-Cal, and falsely represented the amount of time worked at Aspen Day Treatment Center. The circumstances are as follows:

39. Paragraphs 10 through 33 are incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

40. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266 of the Code, in that Respondent failed to maintain adequate medical and billing records by inaccurately documenting services rendered which were not performed and prepared and submitted inaccurate records for billing to Medi-Cal. Respondent also inaccurately represented the amount of time worked at Aspen Day Treatment Center. The circumstances are as follows:

41. Paragraphs 10 through 33 are incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence)

42. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent was grossly negligent in that he wrote progress notes falsely indicating that he had examined patients on a particular dates when, in fact, he had not. The circumstances are as follows:

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43. Paragraphs 10 through 33 are incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

44. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent has committed repeated negligent acts in that he wrote progress notes falsely indicating that he had examined patients on a particular dates when, in fact, he had not. The circumstances are as follows:

45. Paragraphs 10 through 33 are incorporated by reference and realleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 51207, issued to JOHN N.S. RAJARATNAM, M.D.

2. Revoking, suspending or denying approval of JOHN N.S. RAJARATNAM, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering JOHN N.S. RAJARATNAM, M.D., to pay the costs of probation monitoring to the Division, if placed on probation; and

2. Taking such other and further action as deemed necessary and proper.

DATED: 4/30/2007

Matt W. Hoyer for

DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SD2006801851