

## **ISSUE**

Whether the Department properly issued an Order of Summary Suspension to Petitioner on March 4, 2020?

## **FINDINGS OF FACT**

1. Petitioner is a medical doctor, with a National Provider Identifier (NPI) number of REDACTED, who has enrolled as a provider in the Medical Assistance Program (Medicaid) and executed a Provider Enrollment & Trading Partner Agreement with the Department in which she agreed to all of the terms and conditions listed therein. (Respondent's Exhibit A, pages 1-5).
2. On REDACTED, 2020, Petitioner, along with REDACTED REDACTED, was indicted in the United States District Court for the Eastern District of Michigan on two counts of Conspiracy to Commit Healthcare Fraud in violation of 18 USC §§ 1347, 1349. (Petitioner's Exhibit #2, pages 1-11; Respondent's Exhibit B, pages 1-11).
3. On February 3, 2020, Petitioner was released from custody subject to conditions. (Petitioner's Exhibit #3, pages 1-4).
4. One of the conditions was that Petitioner is not to allow her services to be billed under another provider's NPI number or allow the services of another provider to be billed under her NPI number. (Petitioner's Exhibit #3, page 3).
5. On March 4, 2020, the Department issued an Order of Summary Suspension with respect to Petitioner. (Petitioner's Exhibit #1, pages 1-3; Respondent's Exhibit C, pages 1-3).
6. In part, that Order of Summary Suspension stated:

MDHHS OIG has determined that evidence exists in support of the summary suspension of [Petitioner] NPI 1265518567, and such evidence includes but is not limited to:

1. On January 28, 2020, [Petitioner] was indicted in the United States District – Eastern District of Michigan with two counts of Conspiracy to Commit Healthcare Fraud in violation of 18 U.S.C. §§ 1347, 1349. Allegations include:
  - a. [Petitioner] entered into a scheme with REDACTED REDACTED and other co-conspirators to

unlawfully enrich themselves by devising and executing a plan to receive money from Medicare, whereby REDACTED REDACTED – despite being suspended from Medicare or causing Medicare to be billed – would continue to see Medicare patients and cause the patients' treatment(s) to be billed under the name/NPI number of [Petitioner].

- b. [Petitioner] and her co-conspirators materially misrepresented to Medicare which physician was treating said patients, [Petitioner] and REDACTED REDACTED were monetarily compensated by Medicare from this fraud scheme. Specifically, [Petitioner] was compensated by Medicare for patients she never saw or examined.
- c. [Petitioner] and REDACTED REDACTED knowingly caused prolonged billing codes 99354 and 99355 to be billed to Medicare and received monetary reimbursement from Medicaid for billing these codes. The REDACTED would not, however, spend the required face-to-face time with their patients, despite billing and/or causing Medicare to be billed for prolonged visit codes. Medicare would not have reimbursed the REDACTED if it had known they were not spending the required face-to-face time with their patients. Moreover, on certain days it would have been impossible for [Petitioner] and/or REDACTED REDACTED to have spent the required threshold time with their required patients because the time required greater than 24 hours.
- d. Medicare was billed over \$1,000,000 by [Petitioner] and REDACTED REDACTED as a result of the fraud scheme.

[Petitioner] signed a Medical Assistance Provider Enrollment & Trading Partner Agreement on May 12, 2015. By signing that agreement, [Petitioner] agreed to comply with the provisions of 42 CFR §431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation in the Medical Assistance Program is allowed.

Pursuant to Sections 111d, 111e, and 111f of the Social Welfare Act, 1939 PA 280; MCL 400.01 et seq., participation as a provider in the Medicaid program is subject to suspension when:

- A reasonable belief that the provider has violated the Medicaid False Claims Act, Act No. 72 of the Public Acts of 1977, being sections 400.601 to 400.613 of the Michigan Compiled Laws, the health care false claims act, Act No. 323 of the Public Acts of 1984m being sections 752.1001 to 752.1011 of the Michigan Compiled Laws, or a substantially similar statute of another state or the federal government.
- The suspension is necessary to protect the health of medically indigent individuals, the welfare of the public, and funds appropriated for the program.

Pursuant to Section 111f of the Social Welfare Act, MDHHS finds that emergency action is required to protect the public funds of the Medicaid Program, now therefore,

IT IS HEREBY ORDERED that [Petitioner] is summarily suspended from any direct or indirect participation in the Michigan Medicaid Program commencing on February 17, 2020.

*Petitioner's Exhibit #1, pages 1-2*  
*Respondent's Exhibit C, pages 1-2*

7. On March 12, 2019, MOAHR received the request for hearing filed by Petitioner in this matter with respect to the Order of Summary Suspension.

### **CONCLUSIONS OF LAW**

As discussed above, the parties have agreed to have this matter decided on motions/briefs for summary disposition prior to any hearing being conducted.

The Administrative Procedures Act (APA) allows parties "an opportunity to present oral and written arguments on issues of law and policy[.]" MCL 24.272(3). Pursuant to MCL 24.272(3), a party may also pursue a motion for summary disposition to address questions of law that do not involve factual disputes. *Smith v Lansing Sch Dist*, 428 Mich 248, 256-257; 406 NW2d 825 (1987).

MCR 2.116(3) serves as a guide for summary disposition motions under MCL 24.272(3). See, e.g., *American Community Mutual Ins Co v Commr of Ins*, 195 Mich App 351, 361-363; 491 NW2d 597 (1992). Pursuant to MCR 2.116(c)(10), summary disposition is appropriate when there is no genuine dispute of material fact among parties to an action. MCR 2.116(c)(8) also allows summary disposition for failure to state a claim on which relief may be granted.

Furthermore, the Michigan Administrative Code allows for summary disposition under Rule 792.10129, which provides, in pertinent part:

#### **R 792.10129 Summary disposition.**

Rule 129. (1) A party may make a motion for summary disposition of all or part of a proceeding. When an administrative law judge does not have final decision authority, he or she may issue a proposal for decision granting summary disposition on all or part of a proceeding if he or she determines that that any of the following exists:

- (a) There is no genuine issue of material fact.
- (b) There is a failure to state a claim for which relief may be granted.
- (c) There is a lack of jurisdiction or standing.

(2) If the administrative law judge has final decision authority, he or she may determine the motion for summary decision without first issuing a proposal for decision.

(3) If the motion for summary disposition is denied, or if the decision on the motion does not dispose of the entire action, then the action shall proceed to hearing.

Upon review, the undersigned Administrative Law Judge finds that the Department's motion for summary disposition should be granted and its decision to issue an order of summary suspension with respect to Petitioner be upheld.

With respect to orders of summary suspension like the one at issue in this case, the Social Welfare Act of 1939, 1939 PA 280, (Act) as amended, specifically MCL 400.111f, provides in pertinent part:

(1) The director may issue an order incorporating a finding that emergency action is required to protect the state's interest, as the state's interest is described in this subsection by the statement of circumstances warranting emergency action, in any of the following: the public health, welfare, or safety; medically indigent individuals; or public funds of the program of medical assistance. Circumstances that warrant emergency action include, but are not limited to, any of the following:

\* \* \*

(b) A reasonable belief that the provider has violated the Medicaid false claims act, Act No. 72 of the Public Acts of 1977, being sections 400.601 to 400.613 of the Michigan Compiled Laws, the health care false claims act, Act No. 323 of the Public Acts of 1984, being sections 752.1001 to 752.1011 of the Michigan Compiled Laws, or a substantially similar statute of another state or the federal government.

\* \* \*

(5) Upon a determination that circumstances described in subsection (1) exist, the director may issue an order for the summary suspension of payments on pending or subsequent claims, in whole or in part, or for the summary suspension of a provider from participation in the program of medical assistance. The summary suspension shall be effective on the date specified in the order or on service of a certified copy of the order on the provider, whichever occurs later, and shall remain in effect during administrative or judicial proceedings

on the suspension. Upon request of a provider, a contested case hearing pursuant to chapter 4 and chapter 6 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws, shall be commenced not later than 15 days after the summary suspension. If a contested case hearing is requested by a provider relative to an emergency suspension under this section, a hearing shall be held to determine whether the emergency suspension is supported by competent, material, and substantial evidence on the whole record. Under appropriate circumstances, the state department may hold or institute a hearing under section 111c(1), or take an action under section 111d at the same time an action is taken under this section, while an action under this section is pending, or after a decision on an action is made. The presiding officer may consolidate the 2 hearings into a single proceeding in the interest of economy. However, the director shall not make a final decision in a contested case under section 111c(1) or 111d arising from or related to an emergency action or the circumstances upon which an emergency action was taken.

*MCL 400.111f*

With respect to denials, terminations and suspensions of enrollment by providers, the MPM also states in part:

**SECTION 6 – DENIAL OF ENROLLMENT, TERMINATION AND SUSPENSION**

**6.1 TERMINATION OR DENIAL OF ENROLLMENT**

MDHHS may terminate or deny enrollment in the Michigan Medicaid program. Termination of enrollment means a provider's billing privileges have been revoked and all appeal rights have been exhausted or the timeline for appeal has expired. Denial of enrollment means the provider's application will not be approved for participation in the Medicaid program.

MDHHS must terminate or deny a provider's enrollment in Michigan's Medicaid program for the following reasons:

- Termination on or after January 1, 2011 under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state.
- Convicted of a relevant crime described under 42 USC 1320a-7(a):

- Conviction of program-related crimes

Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under subchapter XVIII or under any State health care program.

- Conviction relating to patient abuse

Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

- Felony conviction relating to health care fraud

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph [1]) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

- Felony conviction relating to controlled substance

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Providers who have been excluded due to one of the federal mandatory exclusions listed above will remain on the MDHHS Sanctioned Provider List until the minimum period for their exclusion has been completed and the provider has requested a lifting of their sanction from the sanctioning body.

- Failure to comply with the enrollment requirements of the Social Welfare Act, Public Act 280 of 1939 (MCL 400.111b -111e) and the provider screening and enrollment requirements pursuant to 42 CFR 455.416. The basis for termination or denial of enrollment under this section includes, but is not limited to, the provider's:
  - failure to submit timely and accurate information;
  - failure to cooperate with MDHHS screening methods;
  - failure to submit sets of fingerprints as required within 30 days of a CMS or MDHHS request;
  - failure to permit access to provider locations for site visits;
  - falsification of information provided on the enrollment application or subsequent information requests;
  - inability to verify their identity; or
  - failure to comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries.
- The provider is excluded from participating in a provider capacity in Medicare, Medicaid or any other Federal health care programs.
- The provider is convicted of violating the Medicaid False Claims Act, the Health Care False Claims Act, a substantially similar statute, or a similar statute by another state or the federal government.
- The provider has a federal or state felony conviction within the preceding 10 years of their provider

enrollment application, including but not limited to, any criminal offense related to:

- murder, rape, abuse or neglect, assault, or other similar crimes against persons;
  - extortion, embezzlement, income tax evasion, insurance fraud, and other similar financial crimes;
  - the use of firearms or dangerous weapons; or
  - any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
- The provider has a federal or state misdemeanor conviction within the preceding five years of their provider enrollment application, including but not limited to, any criminal offense related to:
    - any misdemeanor crime listed as a permissive exclusion in 42 USC 1320a-7(b);
    - rape, abuse or neglect, assault, or other similar crimes against persons;
    - extortion, embezzlement, income tax evasion, insurance fraud, or other similar financial crimes; or
    - any misdemeanor that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

For the purposes of the excluded offenses mentioned above, an individual or entity is considered to have been convicted of a criminal offense when:

- a judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending;
- there has been a finding of guilt against the individual or entity by a federal, state, tribal or local court; or

- a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal, or local court.

The criminal history screening will be conducted by MDHHS through reputable and reliable data sources. Screenings for providers will be done as required by law and as deemed necessary by MDHHS for the protection of the Medicaid program and beneficiaries. For criminal offenses that fall under the mandatory exclusions of 42 USC 1320a-7(a), the definition of conviction will conform with 42 USC 1320a-7(i), which may include, but is not limited to, a record relating to criminal conduct that has been expunged.

Any entity that offers, in writing or verbally, discounts on co-pay amounts, fax machines, computers, gift cards, store discounts and other free items, or discounts/waives the cost of medication orders if an entity uses their services:

- may violate the Medicaid False Claim Act and Medicaid/MDHHS policy, which may result in disenrollment from Medicaid/MDHHS programs.
- may violate the Michigan Public Health Code's prohibition against unethical business practices by a licensed health professional, which may subject a licensee to investigation and possible disciplinary action.

Pursuant to MCL 400.111e, the Medicaid Director may terminate or deny enrollment if that action is necessary to protect the health of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program. Additionally, the Medicaid Director may reduce or extend a provider's exclusion from the Medicaid program if, in the Medicaid Director's judgment, the continuation or reduction of the exclusion period is necessary to protect beneficiaries or the Medicaid program.

*MPM, January 1, 2020 version  
General Information for Providers Chapter  
Pages 16-18*

Accordingly, in order to support a summary suspension in this case, the Department must show by competent, material and substantial evidence on the record that there was a reasonable belief that Petitioner violated the Medicaid False Claims Act, the Health Care

False Claims Act, or a substantially similar statute of another state or the federal government.

For the reasons discussed below, the undersigned Administrative Law Judge finds that the Department' motion for summary disposition should be granted, and the summary suspension upheld, because there is no genuine issue of material fact and the Department is entitled to judgment as a matter of law as the Department had a reasonable belief that Petitioner violated a statute of the federal government that is substantially similar to the Medicaid False Claims Act or the Health Care False Claims.

Petitioner has been indicted in the United States District Court for the Eastern District of Michigan on two counts of Conspiracy to Commit Healthcare Fraud in violation of 18 USC §§ 1347 and 1349, with allegations that she and co-conspirators unlawfully and fraudulently billed Medicare for over \$1,000,000, and the record in this case establishes a reasonable belief that Petitioner violated those federal statutes given that Petitioner was indicated pursuant to a grand jury's finding of probable cause that Petitioner committed a crime, see *United States v Sells Eng'g, Inc.*, 463 US 418, 423, 103 S Ct 3133, 3137, 77 LEd2d 743 (1983). A finding of probable cause "requires a quantum of evidence sufficient to cause a person of ordinary prudence and caution to conscientiously entertain a reasonable belief of the accused's guilt.", *People v Yost*, 468 Mich 122, 125, 659 NW2d 604, 606 (2003), and, consequently, the federal indictment alone sufficiently supports the Department's reasonable belief that Petitioner violated the federal statutes she is indicted under.

Moreover, the federal statutes that Petitioner has been indicted under are substantially similar to the Medicaid False Claims Act and Health Care False Claims Act in that all the statutes prohibit and impose liability on persons for knowingly submitting false or fraudulent claims for payment. See 18 USC 1347 and 1349; MCL 400.607; MCL 752.1003. MCL 400.111f does not require that the statutes be exact matches and, while Petitioner asserts that the state and federal statutes differ with respect to the entity receiving the false or fraudulent claims, they are clearly alike in all respects significant or meaningful to this case, and are therefore substantially similar for purposes of MCL 400.111f.

In addition to arguing that the statutes at issue are not substantially similar, Petitioner also argues that a temporary suspension of Petitioner's enrollment is not necessary in this case as MCL 400.111f(1) only permits the Department to issue an order of summary suspension to protect the state's interest in specific areas, such as the public health, welfare, or safety, medically indigent individuals, or public funds of the program of medical assistance, and none of those circumstances are present in this case. In particular, Petitioner asserts that the judge in Petitioner's criminal case permitted Petitioner to continue practicing and billing Medicare, which the judge did not permit for Petitioner's alleged co-conspirator and which demonstrates that it is not necessary to suspend Petitioner even with the allegations against her. Petitioner likewise notes that the judge also set conditions on Petitioner's practice and that the conditions render any emergency action unnecessary. Petitioner further notes that the alleged actions are from years ago

and that Medicaid beneficiaries need providers, especially given the ongoing issues arising from novel coronavirus (COVID-19) pandemic.

However, the order of the federal district court judge is not dispositive in this case and the Department can make its own determination as to whether emergency action is required. Moreover, regardless of whether the Department could have decided as a matter of discretion not to suspend Petitioner, MCL 400.111f expressly states both that circumstances that warrant emergency action include a reasonable belief that the provider has violated the Medicaid False Claims Act, the Health Care False Claims Act or a substantially similar federal statute, and that, in such circumstances, the director may issue an order for summary suspension.

Petitioner further argues that the Order of Summary Suspension violates her right to the presumption of innocence and, given the economic difficulties that will occur if she cannot bill Medicaid, enacts on a hardship on her ability to defend herself in the criminal case.

However, the financial effect of the suspension on Petitioner is irrelevant to this proceeding and, while Petitioner is still presumed to be innocent of the charges against her, the Department is also expressly permitted to take appropriate administrative action and suspend Petitioner's enrollment when there is a reasonable belief that Petitioner violated a federal statute substantially similar to the Medicaid False Claims Act or Health Care False Claims Act.

Accordingly, as the Department has, based on undisputed facts, met its burden of establishing a reasonable belief that Petitioner violated a federal statute substantially similar to the Medicaid False Claims Act and Health Care False Claims Act, the undersigned Administrative Law Judge finds both that the Department's motion for summary disposition should be granted and that the summary suspension should be upheld.

**IT IS THEREFORE ORDERED** that:

- The Department's Motion for Summary Disposition is GRANTED.
- Petitioner's Motion for Summary Disposition is DENIED.
- The Order of Summary Suspension issued by the Department to Petitioner on March 4, 2020 is UPHELD.