

## Suspension ISSUE

Whether the Department properly issued an Order of Summary Suspension to Petitioners' on March 28, 2022?

### FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On February 11, 2014, REDACTED REDACTED signed a Medical Assistance Provider Enrollment and Trading Partner Agreement agreeing to comply with the provisions of 42 CFR §455.104, 42 CFR §455.105, 42 CFR §431.107 and Act No. 280 of the Public Act of 1939. (Exhibit I.)
2. On January 22, 2021, BCC requested pharmacy logs from REDACTED

REDACTED REDACTED after discovering they had filled certain prescription medications linked to "foot bath" schemes. (Exhibit A, p 2; Testimony.)

3. On April 29, 2021, Investigator Courtney LeBlanc, was assigned the task of reviewing REDACTED REDACTED. (Exhibit A, p 2; Testimony.)
4. On June 28, 2021, it was determined a separate audit should be conducted regarding REDACTED REDACTED. (Exhibit A, p 3; Testimony.)
5. As part of the audit, a sample of 99 prescriptions accounting for 188 claims were selected, attestations were sent to prescribers of the claims under review, and wholesaler records were received and reviewed. (Exhibit A, p 3; Testimony.)
6. Of the 188 prescription claims, 117 attestations were received. Of the 117 attestations received, it was reported that for at least 50 of the claims the prescriber denied having ever written the prescription; and 9 prescriptions from 4 other prescribers were returned with general notes stating the patients were not under their care or were not written by the prescriber. (Exhibit A, p 3; Testimony.)
7. On October 4, 2021, following a review of the audit, BCC submitted to the Department, a fraud referral regarding REDACTED REDACTED. (Exhibit F, p 2; Testimony.)
8. On October 8, 2021, the Department forwarded to the Michigan Department of Attorney General, the BCC fraud referral. (Exhibit F, p 2.)
9. On November 19, 2021, the Michigan Department of Attorney General issued a memorandum indicating REDACTED REDACTED was under investigation by the Health Care Fraud Division (HCFD), and that payment suspension in whole or part will not compromise or jeopardize the HCFD investigation. (Exhibit F, p 1; Testimony.)
10. REDACTED is the sole owner of REDACTED REDACTED. (Testimony.)
11. On March 28, 2022, the Department issued Petitioners' an Order of Summary Suspension, summarily suspending Petitioners' from any direct or indirect participation in the Michigan Medicaid program effective March 30, 2022. (Exhibit I.)
12. On April 12, 2022, the Michigan Office of Administrative Hearings and Rules, received from Petitioners' a request for hearing.

## **CONCLUSIONS OF LAW**

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

All Medicaid providers are required to enter into Medicaid Provider agreements:

(4) A provider shall enter into an agreement of enrollment specified by the director.'

The Social Welfare Act, MCL 400.1 *et seq.*, provides that as a condition of participation in the Medicaid program a provider must meet all the requirements listed in MCL 400.111b:

(1) As a condition of participation, a provider shall meet all of the requirements specified in this section except as provided in subsections (25), (26), and (27).<sup>2</sup>

A Medicaid provider must also comply with all Department policies and procedures related to the conditions of participation in the Medicaid program, requirements for Medicaid providers, and with all applicable federal laws and regulations. In particular, the Social Welfare Act plainly states:

(18) A provider shall comply with all requirements established under section 111a (1), (2), and (3).<sup>3</sup>

With respect to orders of summary suspension like the one at issue in this case, the Social Welfare Act, 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:

\* \* \*

<sup>1</sup> MCL 400.111b(4).

<sup>2</sup> MCL 400.111b(1).

<sup>3</sup> MCL 400.111b(18).

(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.<sup>4</sup>

Moreover, with respect to suspension of payments in cases of fraud, 42 CFR 455.23 states in part:

<sup>4</sup> MCL 400.111f.

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(a) Basis for suspension.

- (1) The State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.
- (2) The State Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments.
- (3) A provider may request, and must be granted, administrative review where State law so requires.

...

(c) Duration of suspension.

- (1) All suspension of payment actions under this section will be temporary and will not continue after either of the following:
  - (i) The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.
  - (ii) Legal proceedings related to the provider's alleged fraud are completed.
- (2) A State must document in writing the termination of a suspension including, where applicable and appropriate, any appeal rights available to a provider.

(d) Referrals to the Medicaid fraud control unit.

- (1) Whenever a State Medicaid agency investigation leads to the initiation of a payment suspension in whole or part, the State Medicaid Agency must make a fraud referral to either of the following:
  - (i) To a Medicaid fraud control unit established and certified under part 1007 of this title; or
  - (ii) In States with no certified Medicaid fraud control unit, to an appropriate law enforcement agency.

\* \* \*

A credible allegation of fraud is defined under 42 CFR 455.2 as:

A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

- (1) Fraud hotline tips verified by further evidence.
- (2) Claims data mining.
- (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Fraud is defined under 42 CFR 455.2 as:

*Fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. 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 is a credible allegation of fraud under 42 CFR 455.23; a reasonable belief that Petitioners violated the Medicaid False Claims Act, the Health Care False Claims Act, or a substantially similar statute of another state or the federal government; or an indication of fraud or Medicaid misuse/abuse under MPM Section 6.3.

The referral presented by Blue Cross Complete constituted a credible allegation of fraud that required the Department to suspend participation. The audit, and the review that was completed, revealed 6 responding providers of the 17 who responded, denied writing the prescriptions with a signed attestation. While another 4 responding providers returned unsigned attestations stating the patient in question was not their patient or not in their practice. This information is unusual and concerning even before one considers this all takes place in a high fraud practice area as identified by the Centers for Medicare & Medicaid Services. Consequently, it is reasonable to conclude this warranted a referral to OIG as a credible allegation of fraud. And it is again reasonable that a full investigation would be opened to further investigate the unusual and extremely concerning findings. Consequently, and based on the credible allegation of

fraud determination and corresponding investigation, the Department was required to suspend the Petitioners' participation in the Michigan Medicaid program.<sup>5</sup>

Furthermore, the evidence presented at the hearing by the Petitioners', does not change the Departments' reasonable belief determination. In fact, it does the opposite and creates more questions, and further shows the need for a deeper and more thorough investigation.<sup>6</sup>

Therefore, based on the evidence provided and the applicable policies, rules, and statutes, I find the Department has met its low burden of establishing that a credible allegation of fraud exists, and that emergency action was required to protect state Medicaid funds; and, consequently, the undersigned Administrative Law Judge finds that the summary suspension should be upheld.

**IT IS THEREFORE ORDERED that:**

- **The Order of Summary Suspension issued by the Department to Petitioners' on March 28, 2022, is UPHELD.**