ISSUE

Whether the Department acted properly when it issued an Order of Summary Suspension to Petitioners on May 5, 2022, effective May 9, 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. Petitioner is an enrolled provider in the State of Michigan's Medicaid program. (Petitioners' [Ps'] and Respondent's [R's] Exhibit 1.)

2. On March 10, 2022, Petitioners were sent a Notice of Suspension of Part B Medicare Payments by the Centers for Medicare & Medicaid Services (CMS). (Ps' and R's Exhibit 2.) The Notice indicated that Petitioners' payment suspension was based on credible allegations of fraud pursuant to 42 CFR 405.371(a)(2). (Ps' and R's Exhibit 2.) Specifically, the Notice indicated, in pertinent part:

> . . . the suspension of REDACTED & REDACTED's payments is based on, but not limited to, information that REDACTED & REDACTED misrepresented services billed to the Medicare program. More particularly, REDACTED & REDACTED was identified through a

[1] Attached to the parties' briefs.

> proactive study focusing on high volume of the wound therapy procedure ("Q41"/ "Q42") codes as an outlier for skin substitute procedure codes. A medical review of records obtained from REDACTED & REDACTED confirmed that REDACTED & REDACTED is billing Medicare for skin substitute procedure codes that are not reasonable and necessary and/or not rendered as billed. For ten beneficiaries reviewed, REDACTED & REDACTED billed Medicare excessively for these procedures over a one to two-year period, with claims submitted on average weekly to monthly and some claims even submitted only one to three days apart. The Wound Care LCD 37228 defines wound care as "care of wounds that are refractory to healing or have complicated healing cycles." It further states that "active wound care procedures are performed to remove necrotic tissue and/or devitalized tissue to promote healing" and requires that the "medical record must include a certified plan of care containing a treatment plan with goals, physician follow-up, the expected frequency and duration of the skilled treatment, and the potential to heal." The LCD goes on to require documentation of "ongoing evidence of the effectiveness of the plan, including diminishing area and depth of the ulceration, resolution of surrounding erythema and/or wound exudates, decreasing symptomatology, and overall assessment of wound status (such as stable, improved, worsening, etc.)." The records provided did not support that the wound was refractory to healing or had a complicated healing cycle. It is not normal to be treating the same wound over one to two years using the same treatment, in this case skin substitutes. Whenever a provider assesses a wound, they should be ordering treatment that heals the wound as soon as possible. If there is no improvement the provider should be making changes to the treatment plan.
>
> In addition, based on the wound measurements provided, the quantity of skin substitute billed to Medicare was not appropriate for the wound size. (Ps' and R's Exhibit 2.)

3. On May 5, 2022, MDHHS issued an Order of Summary Suspension, summarily suspending Petitioners' Medicaid enrollment effective May 9, 2022, based on CMS's Notice of Suspension of Part B Medicare Payments. (Ps' and R's Exhibit 1.)

4. On May 13, 2022, after reviewing Petitioners' response to the CMS Notice of Suspension, CMS notified Petitioners that it would be upholding the suspension while it completed its investigation. The response indicated, in pertinent part:

> CMS understands the hardship that a payment suspension can bring to a provider, but it is CMS's responsibility to protect the Medicare Trust Fund and to determine what, if any, remedies are necessary to ensure that providers are billing Medicare correctly. Here, CMS has determined that a full payment suspension and prepay review of Medicare payments is necessary to protect Medicare funds. We note that while the suspension letter included only five claim examples, the determination to suspend REDACTED Medicare payments was not solely based on those five claim examples. A medical review of seventy-five service lines, resulted in a 98.67% denial rate for a lack of medical necessity, services not rendered as billed, and required elements not documented. The primary concern identified during the medical review was the lack of established medical necessity for the billed services, more specifically the overutilization that was found in ten beneficiaries that were billed consistently for one to two years, on average weekly to monthly for skin substitute procedures. Half of those benefits were even billed for services one to three days apart. Moreover, the review also identified that the quantities of skin substitutes billed to Medicare were not appropriate for the wound sizes treated. In addition, the documentation submitted did not support that the billed procedures/services were performed, and there were no certified treatment plans or progress notes for wound care/therapy. Given the findings from the medical review, CMS continues to believe that a full suspension of Medicare payments to REDACTED is necessary to protect Medicare funds. (Ps' Exhibit 3.)

5. On May 6, 2022, Petitioners' request for hearing was received by MOAHR. On May 9, 2022, a Notice of Hearing was issued, scheduling a telephone administrative hearing for May 24, 2022. The May 24, 2022 telephone administrative hearing was converted to a telephone prehearing conference at the request of the parties. At the telephone prehearing conference, the parties agreed to submit the matter for consideration on Cross Motions for Summary Disposition.

6. On May 9, 2022, CMS, responding to an inquiry from the Department, confirmed that the suspension against Petitioners remained in effect and that Petitioners were also on a 100% prepayment review. (R's Exhibit 2.)

CONCLUSIONS OF LAW

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 pursue a motion for summary disposition to address

questions of law that do not involve factual disputes. *Smith v Lansing School 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 Insurance Company v Commissioner of Insurance,* 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. Pursuant to MCR 2.116(c)(8), summary disposition is appropriate when the opposing party has failed to state a claim on which relief can be granted.

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

> (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 [sic] 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.

* * * *

As such, this Administrative Law Judge has the authority to hear and decide preliminary dispositive motions and the authority to issue a decision for summary disposition.

The Social Welfare Act of 1939, 1939 PA 280, (Act) as amended, provides for the summary suspension of Medicaid providers.

MCL 400.111f provides, in pertinent part:

> (1) <u>The director may issue an order incorporating a finding that emergency action is required to protect the state's</u>

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:

(a) A reasonable belief, determined in accordance with professionally accepted standards, that rendered services for which a provider has submitted claims were medically unnecessary, inappropriate, or of inferior quality, and therefore that the continued participation in the program by the provider or payments to the provider for services constitutes a threat to the public health, safety, or welfare or to the health, safety, or welfare of recipient medically indigent individuals.

(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.

* * *

(d) A reasonable belief that 10% or $10,000.00, whichever is less, for a noninstitutional provider, or 10% or $50,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during the most recent 12-month period was unsubstantiated or was for services that were noncovered.

(e) A reasonable belief that 10% or $10,000.00, whichever is less, for a noninstitutional provider, or 10% or $50,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during the most recent 12-month period were medically unnecessary, inappropriate, or of inferior quality.

(f) A reasonable belief that 15% or $15,000.00, whichever is less, for a noninstitutional provider, or 15% or $75,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during a consecutive 12-month period, and that

5% or $5,000.00, whichever is less, for a noninstitutional provider, or 5% or $25,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted during the most recent 12-month period, was for services that were noncovered.

(g) A reasonable belief that 15% or $15,000.00, whichever is less, for a noninstitutional provider, or 15% or $75,000.00, whichever is less, for an institutional provider, of the provider's claims submitted at any time during a consecutive 12-month period, and that 5% or $5,000.00, whichever is less, for a noninstitutional provider, or 5% or $25,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted during the most recent 12-month period, was for services that were medically unnecessary, inappropriate, or of inferior quality.

(h) A reasonable belief that the provider is refusing to comply with section 111b(7), (19), or (25).

* * * *

(5) <u>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.</u> 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(1)(a)-(b), (d-h), (5), Emphasis added)

MCL 400.111d provides, in pertinent part:

> (1) Participation as a provider in the program is subject to denial, suspension, termination, or probation on the grounds specified by section 111e. The director may take 1 or more of the following actions:
>
> (a) Refuse to enroll an applicant.
>
> (b) Suspend a provider indefinitely or for a term certain.

MCL 400.111e provides, in pertinent part:

> (1) The grounds for action by the director under section 111d(1) and the actions to which they may be applied shall be as follows:
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> * * * *
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> (2) The director shall take action under section 111d(1)(a) or (c) if any of the following occurs:
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> * * * *
>
> (f) The provider is suspended or terminated as a provider from participation in the medicaid or medicare program, or other governmentally supported program in any jurisdiction.
>
> (5) In addition to or in place of the grounds specified in subsection (1), (2), or (3), the director may base an action provided for in section 111d(1)(a), (b), (c), (d), (e), or (f) on his or her judgment that the action is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program. (Emphasis added.)

The *Medicaid Provider Manual* contains Medicaid policy in Michigan. It states as follows:

> SECTION 6 - DENIAL OF ENROLLMENT, TERMINATION AND SUSPENSION
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> 6.1 TERMINATION OR DENIAL OF ENROLLMENT
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> 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:
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> - 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.

■ <u>The provider is excluded from participating in a provider capacity in Medicare, Medicaid or any other Federal health care programs.</u>

■ 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.
>
> Providers who are already enrolled at the time of a finding by MDHHS will have their enrollment ended as of the date MDHHS was notified of the excluded offense. Claims with dates of service on and after the provider's enrollment termination date will be denied.
>
> *Medicaid Provider Manual General Information for Providers Chapter January 1, 2022, pp 15-17 Emphasis added*

In this case, the Department argues that the evidence presented supports its summary suspension action because there is no issue of material fact, and the Department is entitled to judgment as a matter of law. In support, the Department relies on the CMS Notice of Suspension of Part B Medicare Payments dated March 10, 2022 as evidence that its Order of Summary Suspension was necessary "to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program," as contemplated in MCL 400.111e(5) and MCL 400.111f(1). Specifically, the Department relies on the following allegations contained in the CMS Notice:

1. On March 10, 2022, the Centers for Medicare and Medicaid Services (CMS) suspended the Medicare payments of REDACTED (aka REDACTED & REDACTED DPM, PC) effective March 4, 2022.

2. This suspension is based on credible allegations of fraud, in accordance with 42 CFR §405.371(a)(2). According to the CMS payment suspension, REDACTED misrepresented services billed to the Medicare program.

   a. More particularly, REDACTED was identified through a proactive study focusing on high volume of wound therapy procedure codes ("Q41/Q42") as an outlier for skin substitute procedure codes.

   b. A medical review of records obtained from REDACTED confirmed billing for skin substitute procedure codes that were not reasonable and necessary and/or not rendered as billed.

   c. For the ten beneficiaries reviewed, REDACTED billed Medicare excessively for these procedures over a one

to two-year period, with claims submitted on average weekly to monthly and some claims even submitted only one to three days apart.

d. The records provided did not support that the wound was refractory to healing or had a complicated healing cycle. It is not normal to be treating the same wound over one to two years using the same treatment, in this case skin substitutes.

e. In addition, based on the wound measurements provided, the quantity of skin substitute billed to Medicare was not appropriate for the wound size.

(P's and R's Exhibits 1, 2)

The Department argues that pursuant to MCL 400.111e(2)(f), Petitioners are ineligible for continued participation in the Michigan Medicaid program because they have been suspended by Medicare. The Department points out that it has no discretion in this matter, and it must terminate Petitioners' enrollment as Medicaid providers in Michigan pursuant to MCL 400.111d(1)(a) and (c). However, the Department argues that it properly moved first for a summary suspension of Petitioners under MCL 400.111f because the underlying reason for the Medicare suspension was a finding of a credible allegation of fraud pursuant to 42 CFR 405.371(a)(2). The Department points out that the standard for a summary suspension is the "reasonable belief' standard found in MCL 400.111f(1)(b) and here, based on the Medicare suspension, the Department had a reasonable belief that Petitioners have "violated the medicaid false claims act . . health care false claims act . . . or a substantially similar statute of another state or the federal government." MCL 400.111f(1)(b).

Petitioners argue that the Department's actions here are unreasonable because those actions exceed the suspension that they rely on. In other words, Petitioners argue that because CMS issued only a payments suspension to Petitioners, the Department should be limited to issuing only a payments suspension from Medicaid. Petitioners point out that they are still able to see patients under the Medicare program but must now get preapproval for any payments submitted during the suspension and while CMS's investigation is completed.

Petitioners further argue that the Department's summary suspension is improper because it has had other detrimental effects beyond preventing Petitioners from treating Medicaid patients and protecting the funds of the Medicaid program. Petitioners point out that the Medicaid suspension also causes private insurances, hospitals, and other health care facilities to terminate Petitioners' privileges even though Petitioners are still able to see Medicare patients, subject to a modified billing process. Petitioners also point out that this summary suspension will soon cause Petitioners to entirely close their practice, affecting 60 employees and 16 years of goodwill with patients. Petitioners further mention that Dr. REDACTED has lost her job as the Director of Podiatry at the REDACTED

and Dr. REDACTED may lose his position as the residency director of podiatric medicine at REDACTED Hospital. Petitioners also point out that many of their patients are unable to refill needed prescriptions because of the Department's summary suspension. Petitioners argue that these detrimental effects are contrary to the intent of MCL 400.111f, which is to protect Medicaid beneficiaries and the Medicaid program.

Petitioners argue that the Department has available to it under MCL 400.111f(5), the ability to order a summary suspension of Medicaid payments, as opposed to a complete suspension from the Medicaid program, and that would be the proper procedure here given Medicare's payments suspension. To that end, Petitioners point out that they agreed to stipulate to such a payments suspension, but the Department declined, even though Petitioners agreed to continue to see Medicaid patients for free.

Having considered the parties' arguments in full, the Department has established by a preponderance of the evidence, that its summary suspension was proper under MCL 400.111d(1), MCL 400.111e(5), and MCL 400.111f(1). Based on the findings by CMS, there were credible allegations of fraud against Petitioners requiring summary suspension "to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program," as contemplated in MCL 400.111e(5) and MCL 400.111f(1). Taken at face value, the allegations in the CMS Notice are serious and the undersigned can take judicial notice of them. *Johnson v Dep't of Natural Resources,* 310 Mich App 635, 648-649 (2015); see also MCL 24.277. Those allegations are more than sufficient to meet the "reasonable belief' standard of proof necessary for the Department to take emergency action under the Social Welfare Act.

As indicated, one of the specific circumstances that warrants emergency action is the "reasonable belief that the provider has violated the medicaid false claims act . . . the health care false claims act . . . or a substantially similar statute of another state or the federal government." MCL 400.111f(1)(b). The rationale for this reduced burden of proof is clear — to allow the Department to take quick and temporary action to protect the Medicaid program while a full investigation takes place. Again, the allegations contained in the CMS Notice are more than sufficient to establish a reasonable belief that such Acts have been violated. Here, the Department will decide on whether to pursue a permanent termination of Petitioners from the Medicaid program once the CMS investigation is completed.

Petitioners' argument that the Department should have imposed a payments suspension as opposed to a suspension of participation in the Medicaid program is without merit. First, the undersigned is unaware of any authority requiring the Department to ever choose one available sanction over another available sanction and Petitioners cite no such authority. Second, Petitioners' arguments in this regard are mostly equitable, *i.e.,* it would be fairer to impose a payments sanction, but the undersigned lacks any equitable powers or authority. *Behavioral Health v Dep't of Community Health,* 293 Mich App 491, 497-498 (2011). A full summary suspension of Petitioners' Medicaid participation was one of the sanctions available to the Department, and it was within the Department's discretion to choose that sanction. Further, given

the seriousness of the allegations, the undersigned agrees with the Department that a full summary suspension was the proper sanction here.

Similarly, Petitioners' arguments that the summary suspension must be improper, and contrary to the intent of the legislature because Petitioners have suffered additional harm due to actions by third parties, such as private insurance companies and hospitals, is without merit. While the undersigned is not unmoved by these consequences, this All only has the authority to consider whether the Department has met its burden of proof, not what ancillary effects the Department's action might have on Petitioners. Having determined that the Department has met this burden, the Department's Order of Summary Suspension is proper and should remain in place.

IT IS THEREFORE ORDERED that:

The Order of Summary Suspension issued by the Department on May 5, 2022, effective May 9, 2022, is **AFFIRMED/UPHELD.**