

## ISSUE

Whether the Department acted properly when it issued an Order of Summary Suspension to Petitioners on February 3, 2023, effective February 6, 2023.

### FINDINGS OF FACT

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

1. Petitioners are enrolled providers in the State of Michigan's Medicaid program. (Exhibits A, B; Testimony.)
2. To become Medicaid providers in Michigan, Petitioners signed Medicaid Provider Enrollment agreements in which they agreed to comply with all regulations, laws, and policies relating to the Medicaid program. (Exhibits A, B; Testimony.)
3. According to Michigan Medicaid records, including the providers' CHAMPS profile, Petitioner REDACTED REDACTED is the 100% owner of Petitioner, REDACTED REDACTED, LLC. (Exhibit D; Testimony.)
4. In 2021, Molina Healthcare, Inc. (Molina), a health plan that contracts with Michigan Medicaid, received a complaint against Petitioners alleging that Petitioners had billed Molina for services to Medicaid beneficiaries that had not actually occurred. (Exhibit C; Testimony.)
5. Following the complaint, Molina's Special Investigations Unit (SIU) Investigator attempted contact with the parents of five Medicaid beneficiaries for whom Petitioners had billed Molina. (*Id.*) Molina's SIU Investigator spoke to three of the five parents and all three indicated that they were not aware of their children receiving any services from Petitioners. (*Id.*)

6. Molina's Registered Nurse (RN) Investigator then completed a post-payment review of 1,155 of Petitioners' claims for 20 Molina members. (Exhibits C, I; Testimony.) The post-payment review identified the following items of concern for 565 of the claims:

The following findings were identified as items of concern:

1) Documentation was not submitted to support the need for the Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) codes billed, and 2) missing documentation to support the services reported. (*Id.*)

7. The post-payment review findings further explained issues with six different CPT codes as follows:

CPT code 90839: (Psychotherapy for crisis; first 60 minutes), 383 dates of service (DOS) did not have supportive documentation. CPT code 90839 was billed for routine psychotherapy sessions without start and stop times indicating the face-to-face time spent with the member.

CPT code 90832: (Psychotherapy, 30 minutes with patient), 14 DOS. This code was billed for meeting with professional staff without member/family present, duration less than 16 minutes. Per CPT manual-less than 16 minutes duration is not billable.

CPT code 90847: (Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes), five (5) DOS. This code was billed for meeting with professional staff without member/family present, duration less than 16 minutes. Per CPT manual-less than 16 minutes duration is not billable.

CPT code 90853: (Group psychotherapy (other than of a multiple-family group)), 12 DOS. This code was billed for the therapist sending text messages to members.

CPT code 90785: (Interactive complexity (List separately in addition to the code for primary procedure)), 86 DOS. No interactive complexity documented.

CPT code 99408: (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services, 15 to 30 minutes), 65 DOS. Members were repeatedly charged for structured

screening, even when no alcohol or substance abuse was identified. No intervention documented.

(Exhibits C, I; Testimony)

8. The post-payment review also identified 238 claims for which medical records were requested, but not provided by Petitioners. (Exhibits C, I; Testimony.)
9. On December 9, 2022, Molina submitted a fraud referral regarding Petitioners to the MDHHS OIG and the Department of Attorney General Health Care Fraud Division (HCFD). (Exhibits C, E; Testimony.)
10. On December 21, 2022, MDHHS OIG wrote to the HCFD to inquire whether they would be accepting the fraud referral from Molina, and if the referral were accepted, the HCFD would request that a payment suspension not be imposed, pursuant to 42 CFR 455.23(e)(1). (Exhibit E; Testimony)
11. On December 22, 2022, the HCFD notified MDHHS OIG that they would be accepting and investigating the fraud referral from Molina, and that a payment suspension would not compromise or jeopardize the HCFD investigation. (Exhibit F; Testimony.)
12. On February 3, 2023, Respondent issued an Order of Summary Suspension to Petitioners, suspending Petitioners from participation in the Michigan Medicaid Program effective February 6, 2023. (Exhibit G; Testimony.) In support of the suspension, the Order indicated, in part:
  1. It is suspected that REDACTED billed for services that were not rendered based on an investigation conducted by Molina Healthcare Inc. (Molina).
    - a. Interviews with the mothers of three Molina members confirmed that counseling services and/or any other treatments billed by REDACTED were not requested, authorized, or received.
    - b. Documentation provided for services billed did not substantiate the services occurred, including 12 dates of service where group psychotherapy was billed for the therapist sending text messages to members.
    - c. Documentation provided for services billed did not substantiate medical necessity.
    - d. REDACTED billed and was reimbursed for services that lacked supportive documentation.

- e. Medical records for 238 claims were requested but not provided.
- f. REDACTED, who is a Licensed Professional Counselor (LPC), is supervising Limited Licensed Professional Counselor (LLPC) interns and co-signing for services that do not meet the standards of care required per the Michigan Administrative Rules, R 338.1774 Application requirements; licensure by examination, that requires 3,000 hours of supervision for full licensure.

2. REDACTED REDACTED, LLC reported to Michigan Medicaid that REDACTED is its sole owner and managing employee.

(Id.)

13. On January 27, 2023, Petitioner's request for hearing was received by MOAHR.

#### CONCLUSIONS OF LAW

Respondent has the burden to show, by a preponderance of the evidence, that it acted properly when it issued an Order of Summary Suspension to Petitioners on February 3, 2023, effective February 6, 2023. *Blue Cross Blue Shield v Milliken*, 422 Mich 1; 367 NW2d 1 (1985). Proof by a preponderance of evidence requires the trier of fact to determine that the evidence supporting the existence of a contested fact outweighs the evidence supporting its nonexistence. *Martucci v Detroit Police Commissioners*, 322 Mich 270; 33 NW2d 789 (1948).

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

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The Act mandates suspension if a provider bills for services not rendered and allows for suspension if the Director determines a suspension is necessary to protect Medicaid beneficiaries or the funds of the program. 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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(3) The director shall take action under section 111d(1)(a), (b), (c), (d), or (f) if any of the following occurs:

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(b) The provider submits a claim for services, supplies, or equipment that was not provided to a recipient.

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(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.)

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(Emphasis added)

The director may also issue an emergency suspension if there is a reasonable belief that the provider has violated the Medicaid False Claims Act or a similar statute. 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:

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(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.

(Emphasis added)

The Act also requires providers to make available any records required to be maintained, such as medical records. MCL 400.111b provides:

(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).

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(7) Upon request and at a reasonable time and place, a provider shall make available any record required to be maintained by subsection (6) for examination and photocopying by authorized agents of the director, the department of attorney general, or federal authorities whose duties and functions are related to state programs of medical assistance under title XIX. If a provider releases records in response to a request by the director made under section 111a(13) or in compliance with this subsection, that provider is not civilly liable in damages to a patient or to another provider to whom, respectively, the records relate solely, on account of the response or compliance.

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Federal regulations require the Department to suspend if there is a credible allegation of fraud and an investigation is pending. 42 CFR 455.23 provides, in pertinent part:

(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.

Suspensions extend to owners of sanctioned entities. 42 CFR 1001.1551 provides, in pertinent part:

(a) Circumstance for exclusion. The OIG may exclude any individual who -

(1) Has a direct or indirect ownership or control interest in a sanctioned entity, and who knows or should know (as defined in section 1128A(i)(6) of the Act) of the action constituting the basis for the conviction or exclusion set forth in paragraph (b) of this section; or

(2) Is an officer or managing employee (as defined in section 1126(b) of the Act) of such an entity.

In this case, the Department argues that it was required to suspend Petitioners because there is a credible allegation of fraud for which an investigation is pending, and because there is a reasonable belief that Petitioners submitted claims for services, supplies, or equipment that were not provided to a recipient. The Department also argues that it had discretion to suspend Petitioners because there is a reasonable belief that Petitioners have violated the Medicaid False Claims Act, or a substantially similar statute, and the suspension is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program.

Petitioners argue that the summary suspension should be lifted because there has been no credible allegation of fraud. Petitioners argue that the parents of the Molina beneficiaries were unaware of Petitioners relationship with School-Based Healthcare Solutions Network, Inc., (SBHSN) through which Petitioners oversaw counseling in the beneficiaries' schools. (Exhibit 2.) Petitioners also argue that the findings from the post-payment review conducted by Molina amount to nothing more than billing mistakes and in no way constitute fraud.

Having considered the parties' arguments in full, the Department has established by a preponderance of the evidence, that its summary suspension was proper under 42 CFR 455.23(a)(1), MCL 400.111d(1), MCL 400.111e(3)(b), MCL 400.111e(5), MCL 400.111f(1)(b), and MCL 400.111b(7).

As indicated above, 42 CFR 455.23(a)(1) requires the Department to suspend Medicaid payments to a provider after the Department determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program. Here, there is an investigation pending by the HCFD, so the only question is whether there is a credible allegation of fraud.

A thorough review of the evidence demonstrates that there is a credible allegation of fraud, so the Department was required to suspend Petitioner's Medicaid payments under state law and federal regulations.

Furthermore, under MCL 400.111e(3)(b), the Act requires the Department to suspend a provider if there is a reasonable belief that the provider submitted a claim for services, supplies, or equipment that was not provided to a recipient. A thorough review of the evidence demonstrates that the Department had such a reasonable belief.

After receiving a complaint in 2021 that Petitioners had billed Molina for services to Medicaid beneficiaries that had not actually occurred, Molina investigated. Molina's SIU Investigator spoke to three parents of Medicaid beneficiaries who all indicated that they were not aware of their children receiving any services from Petitioners, even though Petitioners had billed Molina for said services. Molina's RN Investigator then completed a post-payment review of 1,155 of Petitioners' claims for 20 Molina members and discovered that there were issues with 565 of the claims, including serious issues with six CPT codes billed. The post-payment review also identified 238 claims for which medical records were requested, but not provided by Petitioners.

Molina forwarded these allegations to MDHHS OIG and the Attorney General's HCFD. The allegations were credible enough that the HCFD accepted the referral and opened a criminal investigation, that is still pending. The allegations are also credible on their face: three individuals indicating that their children were not treated by Petitioners even though Petitioners billed Molina for services, and issues with 565 claims that Petitioners signed off on. So, at the time Respondent issued its summary suspension, there were credible allegations of fraud.

And, after hearing Petitioner REDACTED REDACTED's testimony, the undersigned is even more convinced that there are still credible allegations of fraud to support the suspension. Basically, Petitioner REDACTED testified that she contracted with another organization (SBHSN) and let that organization use her NPI number and her company's NPI number to bill Molina for services that she did not provide, and for services she did not verify. Specifically, Petitioner REDACTED reviewed and signed off on services provided by Limited Licensed Professional Counselors (LLPC's) working under her supervision through SBHSN, but never verified whether the services she signed off on matched what SBHSN billed Molina for.

Clearly, as Respondent pointed out at the hearing, this situation was ripe for fraud, and Petitioners, as the individual and the entity billing Molina, would be responsible for any fraud that may have occurred. Here, allegations included billing for psychotherapy in crisis on 383 dates of service, when there was no crisis; billing for psychotherapy with a patient when there was no patient present; billing for psychotherapy with a parent when there was no parent present; billing for group psychotherapy when sending text messages; billing for complex cases when there was no documented complexity; and billing for alcohol and substance abuse therapy when no such issues were documented.

Therefore, there was a credible allegation of fraud and the Department's suspension pursuant to 42 CFR 455.23(a)(1) was proper.

In addition, based on the same facts, there was a reasonable belief that Petitioners submitted claims for services, supplies, or equipment that was not provided to a recipient. While the three parents Molina talked to were probably unclear about Petitioners' relationship with SBHSN; when there are issues with close to 50% of the claims reviewed, that is much more than a billing mistake. As such, the Department was required to suspend Petitioners under MCL 400.111e(3)(b).

Finally, also based on the same facts, the Department properly used its discretion to suspend Petitioners pursuant to MCL 400.111e(5) (the action was necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program) and MCL 400.111f(1)(b) (a reasonable belief that the provider violated the Medicaid false claims act or a substantially similar statute of another state or the federal government).

Having determined that the Department has met its 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 February 3, 2023, effective February 6, 2023, is **AFFIRMED/UPHELD**.