

## **ISSUE**

Whether the Department's Order of Summary Suspension is supported by competent, material, and substantial evidence on the whole record.

## **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. (Exhibit A, pp 261-271; Testimony.)
2. In May of 2023, MCE Lapeer contacted Health West with concerns Petitioner was working for three different MCE's. (Exhibit A, p 17; Testimony.)

3. Following the contact, Oakland County Health Network contacted the Department and asked the Department to run a CHAMPS report to identify overlapping services. (Exhibit A, p 17; Testimony.)
4. Following receipt of the report, Oakland County Health Network reached out to Lakeshore Regional Entity and Lapeer and asked for Service Activity Logs (SAL) detailing claims and times.(Exhibit A, p 17; Testimony.)
5. Petitioner was responsible for the entries in the SAL reports and entered the dates, the begin times, the end times, the contact type, the information contained in the notes, and signed the notes. (Testimony.)
6. The SAL identified numerous overlaps.(Exhibit A, pp 105-198; Testimony.)

DATE	Beneficiary Encounter 1	Beneficiary Encounter 2	Bates page Number
5/4/23	10:04-10:14	10:04-10:23	102
11/30/22	11:40-12:05	11:58-12:14	115
7/12/22	1:30-1:50	1:30-1:30	131
5/10/22	11:30-11:50	11:40-12:00	137
7/1/21	4:00-4:15 & 4:20-4:40	4:00-4:30	170
6/2/21	10:40-11:11	9:30-11:00	172
4/27/21	12:30-1:00	12:30-1:00	175
3/5/21	11:10-11:35	11:30-12:00	179
2/26/21	9:30-10:00	9:30-10:00	180
2/26/21	1:30-2:00	1:00-2:30	180
2/22/21	10:50-11:10	11:00-1:30	180
2/18/21	9:20-9:50	9:00-9:30	181
2/18/21	2:30-2:50	2:00-2:30	181
2/1/21	2:30-2:55	2:00-3:30	182

1/25/21	10:00-10:20 & 10:21-10:40 & 10:45-11:10	9:30-11:00	183
1/11/21	9:45-9:57 & 10:10-10:30	9:30-11:00	184
12/29/20	8:45-9:10	9:00-9:30	185
12/29/20	10:20-10:40	9:30-11:00	185
12/29/20	11:10-11:40	11:00-11:30 & 11:30-12:00	185
12/17/20	9:45-10:10 & 10:25-10:45	9:30-11:00	186
8/27/20	12:30-1:00	12:30-1:00	194
8/27/20	2:30-2:55	2:00-3:30	194
7/29/20	4:00-4:30	3:30-4:30	196
7/9/20	8:30-8:55	8:30-9:00	197
7/9/20	2:00-2:45	2:00-3:30	198

7. On January 3, 2024, Oakland County Health Network, submitted to the Department a fraud referral after reviewing the data and concluding there was a sufficient level of evidence to support a fraud allegation. (Exhibit A, pp 16-21; Testimony.)
8. On January 12, 2024, the Department forwarded the fraud referral and documentation to the Michigan Medicaid Fraud Control Unit (MFCU). (Exhibit A, p 12; Testimony.)
9. Upon receiving the referral, the MFCU found the allegations to be credible and opened an investigation. As of the date of the hearing, the investigation remains ongoing. (Exhibit A, p 11; Testimony.)
10. On February 5, 2024, following a review of allegations and the underlying evidence, the Department issued an Order of Summary Suspension summarily suspending Petitioner's Medicaid enrollment effective February 6, 2024. (Exhibit A, pp 9-12; Testimony.)

## 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.<sup>2</sup>

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>3</sup>

Pursuant to the Social Welfare Act and the Petitioner's Medicaid Provider Agreement, Petitioner is required to follow all applicable Medicaid policy.<sup>4</sup>

A Medicaid provider must 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>5</sup>

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) 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

---

<sup>2</sup> MCL 400.111b(4).

<sup>3</sup> MCL 400.111b(1).

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

<sup>5</sup> MCL 400.111b(18).

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) 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>6</sup>

---

<sup>6</sup> MCL 400.111f(1)(a)-(h).

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:**

\*\*\*\*

**(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.)<sup>8</sup>**

In addition, 42 CFR 455.23 provides for suspension of a Medicaid provider upon the finding of a credible allegation of fraud:

**(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.**

\*\*\*\*

**(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:**

---

<sup>7</sup> MCL 400.111d.

<sup>8</sup> MCL 400.111e.

(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.

\*\*\*\*

(<sup>3</sup>)

(i) If the Medicaid fraud control unit or other law enforcement agency accepts the fraud referral for investigation, the payment suspension may be continued until such time as the investigation and any associated enforcement proceedings are completed.

\*\*\*\*

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.

Emphasis added.

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.

Emphasis added.

As such, to support a summary suspension, the Department must show by competent, material, and substantial evidence on the whole record that there is a credible allegation of fraud under 42 CFR 455.23, that the summary suspension is necessary to protect the

health of medically indigent individuals, the welfare of the public, or the funds appropriated for the Medicaid program under MCL 400.111e(5).

The evidence provided indicates there were multiple occurrences where Petitioner was allegedly with different patients on the same date, at the same time. These overlapping encounters were billed and paid by Medicaid. Furthermore, these overlapping encounters allowed for Petitioner to receive multiple paychecks from multiple employers for no additional time spent. Consequently, and based on this information, the Department suspended Petitioner as they determined there was a credible allegation of fraud based on those facts which required further investigation.

As discussed above, the Department is mandated to suspend in cases where there is a credible allegation of fraud. And as determined by the Legislature, the Department only must meet a reasonable belief standard when taking emergency action under the Social Welfare Act.<sup>9</sup> Among the specifically listed circumstances that warrant emergency action is the "reasonable belief that the provider has violated the medicaid false claims act . . . healthcare false claims act . . . or a substantially similar statute of another state or the federal government."<sup>10</sup>

Petitioner does not contest the overlapping encounter dates/times or the fact he entered the overlapping encounter dates/times in the SALs. Instead, Petitioner argues that over the past 3 and half years, the allegations apply to less than 1% of his patient claims and further that of the thirty-four true overlaps, thirty-one of them are due to Petitioner not changing the appointment window times at Health West as the timing did not matter for billing purposes". The Petitioner further pointed out that two of the incidents were the result of an overlap of documentation, and the remaining incident was an inadvertent error. Petitioner further argued that none of the overlaps were intentional, willful, or knowingly; and that Petitioner saw every patient for every visit at issue.

Having reviewed the evidence and the arguments presented by each party, I find the Department to be correct in that Petitioner's testimony and arguments do not negate the Department's evidence. Instead, they only add an additional layer that should and must be investigated.<sup>12</sup> The Department also correctly points out that this is a preliminary matter, and the Department must only reach the low standard of "reasonable belief" to allow the suspension to stand during a full investigation.

Consequently, I find the evidence presented is sufficient to meet the reasonable belief standard and the definition of a credible allegation of fraud and further that as a result, the Department properly suspended Petitioner from participation in the Medicaid

---

<sup>9</sup> MCL 400.111f(1).

<sup>10</sup> MCL 400.111f(1)(b).

<sup>11</sup> The two billing codes used are not affected by the amount of time seen. (Testimony)

<sup>12</sup> The Petitioner's testimony itself is mostly self-serving in the absence of supporting evidence.

Furthermore, while some witnesses were able to testify and corroborate that some of the beneficiaries were seen, not all of the witnesses could do so, nor could they testify that each of the beneficiaries were seen.

Program in order to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program.

**IT IS THEREFORE ORDERED** that:

The Order of Summary Suspension issued by the Department on February 5, 2024, effective February 6, 2024, is **AFFIRMED**.