

ISSUE

Whether the Department acted properly when it issued an Order of Summary Suspension to Petitioner on August 16, 2024, effective August 21, 2024.

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 (Ex) S; Testimony.)
2. On January 23, 2024, Petitioner was referred to the Special Investigations Unit (SIU) by REDACTED; and an audit was initiated for the time period of January 1, 2023, through January 15, 2024. (Exhibit F; Testimony.)
3. On March 18, 2024, Petitioner was referred to the SIU by REDACTED as a result of an investigative audit and internal tip Petitioner was excessively billing Covid-19 test kits for high reimbursement. (Exhibit F.)
4. On April 8, 2024, REDACTED placed the Petitioner on a payment and temporary adjudication suspension based on the findings of their audit. (Exhibit F.)
5. On April 12, 2024, REDACTED terminated Petitioner from their network. (Exhibit F.)
6. In May of 2024, REDACTED finalized their audit which determined 472 affected Medicaid claims for Prescriber Denial after REDACTED had contacted Dr. REDACTED who denied writing all prescriptions for the COVID-19 RAP KIT 2-PACK and identified an overpayment of \$124,241.60. (Exhibit F.)

7. On May 21, 2024, REDACTED finalized their audit finding 421 Medicaid claims for drug invoice shortages on the CLINITEST KIT SELF-TST. 5 test kit claims had an additional discrepancy for patient denial and 16 test kit claims had an additional discrepancy of other. There were 2 additional invoice shortages each on FEXOFENADINE TAB 180MG, HYDROCO/APAP TAB 10-325MG, and LARIN FE TAB 1/20 for a total identified overpayment of \$41,587.85. (Exhibit F.)
8. On July 2, 2024, Meridian Health Plan submitted a fraud referral to the Department. (Exhibit E; Exhibit F; Testimony.)
9. On July 10, 2024, the Department sent the fraud referral to the Health Care Fraud Division. (Exhibit E; Testimony.)
10. On July 11, 2024, the Health Care Fraud Division indicated the Petitioner was under investigation and a payment suspension in whole or part would not compromise or jeopardize their investigation. (Exhibit D.)
11. On August 16, 2024, the Department sent the Petitioner an Order of Summary Suspension, summarily suspending Petitioner "from direct or indirect participation in the Michigan Medicaid program commencing August 21, 2024." The order also suspended Petitioner from "participation in any Managed Care Organization (MCO) that is enrolled in the Michigan Medicaid Program." (Exhibit C; Testimony.)
12. The August 16, 2024, suspension of Petitioner was based on the following:
 - i. It is suspected that REDACTED Pharmacy engaged in a scheme using falsified prescriptions and unsolicited phone calls to bill Medicaid for medically unnecessary COVID test kits.
 - ii. Meridian Health Plan and its Pharmacy Benefit Manager (PBM), REDACTED, performed an investigation for which findings suggested that REDACTED Pharmacy was excessively billing Covid-19 test kits for high reimbursement. Additional findings from the investigation include:
 1. The pharmacy had a large volume of claims associated with a single prescribing provider, Dr. REDACTED.
 - a. Dr. REDACTED was listed as the prescribing provider on 100% of the COVID-19 test kit claims with Meridian Health Plan.

- b. REDACTED contacted Dr. REDACTED who denied prescribing any of the COVID-19 test kits. Dr. SREDACTED stated she practices in Texas and denied knowing REDACTED Pharmacy.
 - c. REDACTED identified an overpayment of \$124,241.60 tied to 472 claims.
2. Meridian Health Plan's Special Investigation Unit (SIU) conducted member outreach and received 12 verbal denials. Of the 12 members reached, 11 stated they had received an unsolicited phone call telling them they were eligible to receive free COVID-19 test kits. None of the members gave their Medicaid billing information or permission to bill. All 12 members denied knowing Dr. REDACTED and REDACTED Pharmacy.
3. A drive by visit was conducted on February 12, 2024, due to a tip received from a beneficiary stating the pharmacy was closed or out of business. The investigator found that the pharmacy did not appear to be open or in business but was actively billing claims.
- iii. Meridian Health Plan's prior PBM, REDACTED, also completed an audit on REDACTED Pharmacy, which identified an invoice shortage of 421 claims for CLINITEST COVID-19 test kits. In addition, two other medications were found to have shortages, for a total overpayment identified of \$41,587.85.²
13. On September 3, 2024, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a Request for Hearing.

CONCLUSIONS OF LAW

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

Pursuant to 42 CFR §455.23, MDHHS must suspend all Medicaid payments to a provider after a department 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 Exhibit C, pp 1-2.

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 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.
- The provider dispenses, renders, or provides services, supplies, or equipment without a practitioner's prescription or order.
- The suspension is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program.

In this case, the Department argues they must suspend after it was determined there was a credible allegation of fraud for which an investigation is pending.³ Specifically, the Department points to the independent investigations conducted by REDACTED, ESI and Meridian and the current ongoing investigation being conducted by the Michigan Medicaid Fraud Control Unit.

REDACTED found evidence of fraud, and a failure to produce evidence to show purchase/payment of 427 kits totaling \$41,587.85 and consequently issued a payment suspension effective April 8, 2024. ESI on the other hand identified 472 discrepant claims totaling \$124,241.60 and terminated Petitioner's participation effective April 12, 2024. Thereafter, Meridian conducted their own investigation which included a claims data review, member outreach, and an on-site review. Meridian's investigation found Petitioner engaged in a scheme for unnecessary COVID-19 kits.

Following Meridian's investigation, Meridian forwarded their findings to the Office of Inspector General, wherein a three-panel committee reviewed Meridian's referral, its own internal data, and concluded the allegations were supported by the evidence to support a credible allegation of fraud. Consequently, the OIG then referred the matter to the Michigan Fraud Control Unit where the matter is currently undergoing a full investigation.

Petitioner argues that the evidence presented by Respondent fails to give rise to a credible allegation of fraud "specifically attributable to [Petitioner]".⁴ This argument, however, fails in light of the totality of the evidence presented and the circumstances involving three different entities at the center of the allegations. It isn't enough for the Petitioner to argue it wasn't them but that "something stinks here", while completely

³ 42 CFR §455.23.

⁴ Petitioner's Closing Brief, p 1.

ignoring the allegations that Dr. REDACTED made statements that she did not write the prescriptions implicating either REDACTED, or Petitioner, or both.

Next, the petitioner goes on to argue that the Department failed to establish that since the order was issued that a single aspect of Petitioner's operations require that the suspension still be maintained. This, however, ignores §455.23 which requires a suspension after an agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program..."⁵

The remainder of Petitioner's closing brief focuses on the Department not introducing evidence of a certification from the Medicaid fraud control unit indicating the matter is still under investigation. This issue, however, is not on appeal. At this time, the focus is on the initial Order of Summary Suspension issued August 16, 2024.

Based on the totality of the evidence it is likely a Medicaid-fraud scheme exists. The degree of involvement for the Petitioner, however, is still under investigation by the Michigan Medicaid Fraud Control Unit. And while Petitioner claims they are 100% free from any involvement, five different entities determined Petitioner's practice actionable. Four of those entities terminated or suspended Petitioner, and the fifth entity, the Michigan Medicaid Fraud Control Unit, is currently investigating the matter.

Consequently, based on the evidence presented, I find the Department has met its burden and 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 August 16, 2024, effective August 21, 2024, is **AFFIRMED**.