STATE OF NORTH CAROLINA COUNTY OF WAKE	IN THE OFFICE OF ADMINISTRATIVE HEARINGS 11 DHR 14232
JOHN S. WON Petitioner, v. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, Respondent.	**DECISION**

THIS MATTER came on for hearing before Senior Administrative Law Judge Fred G. Morrison Jr., on May 4, 2012, in Raleigh, North Carolina.

APPEARANCES

For Respondent: Tracy J. Hayes
Special Deputy Attorney General
N.C. Department of Justice
Raleigh, North Carolina

For Petitioner: Carrie E. Meigs
Teague, Campbell, Dennis & Gorham
Raleigh, North Carolina

ISSUE

Whether the decision of Respondent's Hearing Officer to uphold DMA's suspension of payments to Petitioner in accordance with 42 C.F.R. § 455.23 was erroneous, contrary to law, rule or procedure, or arbitrary and capricious.

EXHIBITS

For Respondent: Exhibits 1 – 13, 15 and 16 were admitted.

For Petitioner: Exhibits 1, 2, 5 and 6 were admitted.

TESTIMONY

Paula Blake, DMA Program Integrity Dental Investigator and North Carolina Licensed Dental Hygienist, testified on behalf of Respondent at the hearing on May 4, 2012 in Raleigh, North Carolina. Petitioner testified on his own behalf at the hearing.

APPLICABLE STATUTES, RULES, REGULATIONS AND POLICIES

1. The Social Security Act, 42 U.S.C. 1396 *et seq.*
2. 42 CFR § 455.2
3. 42 CFR § 455.23
4. Federal Register, Vol. 76, No. 22
5. North Carolina Administrative Code, Title 10A, Subchapter 22F
6. February 2009 Medicaid Bulletin

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing, along with documents and exhibits received and admitted in evidence and the entire record in this proceeding, the Undersigned makes the following Findings of Fact. In making the Findings of Fact, the Undersigned has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate factors for judging credibility, including but not limited to the demeanor of the witness, any interests, bias, or prejudice the witness may have, the opportunity of the witness to see, hear, know, or remember the facts or occurrences about which each witness testified, whether the testimony of the witness is reasonable, and whether the testimony is consistent with all other believable evidence in the case.

FINDINGS OF FACT

1. Respondent, the Department of Health and Human Services ("DHHS"), is the single state agency responsible for administering the North Carolina Medicaid program in accordance with federal and state law pursuant to the Social Security Act, N.C.G.S. §108A-25(b), §108A-54 and the North Carolina State Plan for Medical Assistance. The Division of Medical Assistance ("DMA") is a Division of DHHS and is responsible for ensuring the integrity of the Medicaid program by conducting investigations and monitoring of enrolled NC Medicaid providers and implementing sanctions, including payment suspensions.

2. Petitioner is enrolled in the North Carolina Medicaid program to deliver dental services under Medicaid number 5901093 pursuant to a North Carolina Medicaid Provider Administrative Participation Agreement executed by him on January 12, 2010, for a site location at 3600 Northwest Cary Parkway, Suite 105, Cary, North Carolina(T pp 37-38 and Respondent's Exhibit 9), where he sees approximately 30-50 Medicaid patients per week (T p 19).

3. Petitioner has been a Medicaid provider since around 2005. (T p 35).

4. In accordance with the requirements of 42 C.F.R. § 455.23, DMA suspended Petitioner's Medicaid payments on September 7, 2011, based upon a referral from the Medicaid Fraud Investigations Unit, which constitutes a "credible allegation of fraud" pursuant to 42 C.F.R. § 455.2. Petitioner does not dispute whether he received proper notice of DMA's action or make any allegations that his due process rights were violated.

5. As of the date of the hearing, DMA had suspended from Dr. Won a total of $589,438.43 in payments for 2011 and $14,503.58 in payments for 2012. (T p 84; Respondent's Exhibit 16).

6. In addition to operating from his enrolled site location in Cary, Petitioner contends that he traveled to satellite offices owned and operated by other dental providers and performed oral surgery in Alamance, Brunswick, Chatham, Durham, Granville, Johnston, Moore, Person, Vance, New Hanover, and/or Onslow counties approximately once per month. (T pp 22, 25-26).

7. Petitioner claims that he contracted with Dr. Anna Goodrich, a general dentist in Southern Pines (Moore County) North Carolina, in order to provide care to Dr. Goodrich's Medicaid patients. (T pp 27-28). Petitioner did not provide this tribunal with a copy of that contract.

8. Petitioner also claims that he contracted with Dr. Benjamin Koren, a general dentist with offices in Creedmoor (Granville County), Smithfield (Johnston County), Pittsboro (Chatham County), Roxboro (Person County) and Leland (Brunswick County), in order to provide care to Dr. Koren's Medicaid patients. (T p 29). Petitioner did not provide this tribunal with a copy of that contract.

9. Regardless of any side agreements with other providers that Petitioner may or may not have entered into, Petitioner's Medicaid Participation Agreement specifies "That the assigned Tracking/DHHS Provider Number is specific to the provider name and site location identified on page one of this Agreement, and that the provider shall not bill for services provided at or from other site locations using the Tracking/DHHS Provider Number assigned to the site location identified on page one of this Agreement." (Respondent's Exhibit 9, Paragraph 5.r.; T pp 37-38).

10. The February 2009 Medicaid Bulletin promulgated by the Department and published on the DMA website also specifies that "Sole proprietors or single owner LLC providers who have more than one physical service location are required to submit an application for and be issued an individual Medicaid Provider Number (MPN) for each of their physical service locations." (Respondent's Exhibit 10; T p 39).

11. Petitioner agreed "to operate and provide services in accordance with all federal and state laws, regulations and rules, and all policies, provider manuals, implementation updates and bulletins published by the Department, its Divisions and/or its fiscal agent in effect at the time the service is rendered, which are incorporated into this Agreement by this reference." (Respondent's Exhibit 9, Paragraph 3; T pp 35-36).

12. Petitioner admits that all of his services were billed from his Cary (Wake County) office using the Medicaid billing number assigned to that office. Petitioner did not bill through the group practices with which he claimed to be affiliated in other site locations. (T p 41).

13. Even if Petitioner provided services to patients who lived in HRSA medically-underserved areas within Alamance, Brunswick, Chatham, Durham, Granville, Johnston, Moore, Person, Vance, New Hanover, or Onslow Counties, these services were provided in direct

violation of Petitioner's Medicaid Participation Agreement and the February 2009 Medicaid Bulletin directed at dental providers.

14. There are other oral and maxillofacial surgeons who provide services to Medicaid recipients in Alamance, Brunswick, Durham, Moore, Vance, New Hanover, and Onslow Counties. (T pp 41-43).

15. There are other general dentists who provide services to Medicaid recipients in Brunswick, Chatham, Johnston and Person counties. Further, recipients in Chatham and Person counties have access to a large number of dental providers, including oral and maxillofacial surgeons, in Durham and Orange counties.

16. The HRSA medically-underserved classification is complex and may only apply to discrete parts of a particular county, as opposed to the entire county. (T p 67).

17. There are areas within Chatham County, Johnston County, Person County and Granville County that are designated as medically-underserved areas, but Petitioner did not provide evidence showing that any of his patients specifically resided in medically-underserved areas. (T pp 67).

18. Petitioner also did not show that he provided services to a "large number" of recipients residing within an HRSA medically-underserved area. (T p 69).

19. Petitioner also did not show that he has made any attempts to receive a Medicaid Provider Number for any practice locations other than his primary location in Cary, NC.

20. DMA fairly and seriously considered Dr. Won's contention that he should be granted a good cause exception for serving patients in medically-underserved locations. (T p 67). DMA also considered the other areas where Petitioner provided care in violation of his Agreement, the impact that the continued suspension of Medicaid reimbursements would have on Petitioner's oral and maxillofacial surgery practice and the potential impact on access to care.

21. Access to patient care will not be jeopardized if the suspension of Petitioner's Medicaid reimbursements continues.

CONCLUSIONS OF LAW

Based on the foregoing facts, the Undersigned makes the following Conclusions of Law:

1. The North Carolina Office of Administrative Hearings has jurisdiction over the parties and subject matter of this contested case pursuant to N.C.G.S. §150B-23 *et seq.* All necessary parties have been joined. The parties have received proper and timely notice of the hearing in this matter.

2. To the extent that the findings of facts contain conclusions of law, or that the conclusions of law are findings of fact, they should be so considered without regard to the given labels. *Bonnie Ann F. v. Callahen Indep. Sch. Bd.,* 835 F. Supp. 340 (1993).

3. Pursuant to 42. C.F.R. § 431.10 (e), the authority of the State Medicaid agency "must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State. If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency."

4. There is no property interest in approved Medicaid payments for services rendered or in participation in the North Carolina Medicaid program. *See, e.g., St. Joseph Hospital v. Electronic Data Systems, Inc. et al.*, 573 F. Supp. 443, 447 (S.D. Tx. 1983). Provider participation in the NC Medicaid program is contract-based. In North Carolina, all Medicaid provider "contracts are terminable at will" and nothing in the regulations governing the NC Medicaid program "creates in the provider a property right or liberty right in continued participation in the Medicaid program." 10 N.C.A.C. § 22F.0605.

5. In order to prevail on his administrative appeal, the Petitioner must be able to show that the "respondent has deprived the petitioner of property, has ordered the petitioner to pay a fine or civil penalty, or has otherwise substantially prejudiced the petitioner's rights, and that the agency: (1) Exceeded its authority or jurisdiction; (2) Acted erroneously; (3) Failed to use proper procedure; (4) Acted arbitrarily or capriciously; or (5) Failed to act as required by law or rule." N.C.G.S. § 150B-23(a) (emphasis added). Because Petitioner has failed to show that the agency committed any of the prohibited actions enumerated in N.C.G.S. § 150B-23(a)(1)-(5), Petitioner cannot succeed on his appeal.

6. The burden of proof rests on the petitioner challenging an agency decision. *Overcash v. N.C. Dep't of Env't & Natural Res.*, 635 S.E. 2d 442, 448 (N.C. Ct. App. 2006), *cert. denied*, 361 N.C. 220 (2007).

7. Respondent is entitled to deference in its interpretation of its own policies and procedures, including its interpretation of the Medicaid Provider Administrative Participation Agreement, Medicaid Billing Guide and February 2009 Medicaid Bulletin. "It is well established 'that an agency's construction of its own regulations is entitled to substantial deference.'" *Morrell v. Flaherty*, 338 N.C. 230, 237-238, 449 S.E.2d 175, 179-180 (1994), citing *Martin v. OSHRC*, 499 U.S. 144, 150-51, 113 L. Ed. 2d 117, 127, 111 S.Ct. 1171 (1991). Moreover, the "agency's interpretation must be given 'controlling weight unless it is plainly erroneous or inconsistent with the regulation.'" *Id.*, citing *Udall v. Tallman*, 380 U.S. 1, 16-17, 13 L. Ed. 2d 616, 625-26, 85 S. Ct. 792 (1965). DMA's interpretation that Dr. Won's billing practices violated the Agreement, the Billing Guide and the Medicaid Bulletin is not plainly erroneous or inconsistent with the regulations.

8. 42 C.F.R. § 455.23(a)(1) requires the State Medicaid agency to "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." If a State Medicaid agency does not undertake such a suspension, it is at risk of not

receiving the federal financial participation (FFP) for the State's Medicaid program. 42 C.F.R. § 455.23(a). Respondent acted as required by this regulation.

9. 42 C.F.R. § 455.23(e) states that "[a] State may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable" and lists six possible exceptions, including "(4)(i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community" or "(ii) The individual or entity serves a large number of beneficiaries within a HRSA-designated medically underserved area."

10. 42 C.F.R. § 455.23(c)(5) further states that "[a] *State's decision to exercise* the good cause exceptions in paragraphs (e) or (f) of this section not to suspend payments or to suspend payments only in part does not relieve the State of the obligation to refer any credible allegation of fraud as provided in paragraph (d)(1) of this section." (emphasis added).

11. In responding to public comments submitted as part of the promulgation of 42 CFR § 455.23(e), the Centers for Medicare and Medicaid Services (CMS) stated that "we are concerned about negatively impacting beneficiary access to care… the good cause exception *may* be applied when a beneficiary's access to care is jeopardized because he/she cannot obtain necessary services from a particular provider type." 76 Fed. Reg. 5862, 5937 (emphasis added). Had CMS wanted to require States to apply the good cause exception in all such cases, the regulation and Federal Register would have used the word "shall."

12. The North Carolina Supreme Court has repeatedly held that use of the term 'may' "generally connotes permissive or discretionary action and does not mandate or compel a particular act." *Campbell v. First Baptist Church*, 298 N.C. 476, 483, 259 S.E.2d 558 (1979), quoting *Felton v. Felton*, 213 N.C. 194, 195 S.E. 533 (1938). Furthermore, the preamble to 42 CFR § 455.23(e) notes that the enumerated "good cause" exceptions listed in 42 § 455.23(e)(1)-(6) are those "by which States <u>may</u> determine good cause exists. . . ." 76 Fed. Reg. 5862, 5933 (emphasis added).

13. "If the language used is clear and unambiguous, the Court does not engage in judicial construction but must apply the statute to give effect to the plain and definite meaning of the language." *Fowler v. Valencourt*, 334 N.C. 345, 348, 435 S.E.2d 530, 532 (1993).

14. Petitioner's argument that DMA is required to exercise the good cause exception is not supported by the plain language of the regulation or even the Federal Register, both of which clearly give the State the discretion to determine whether to exercise the good cause exception. 42 C.F.R. 455.23(c)(5).

15. "In determining whether an agency decision is arbitrary or capricious, the reviewing court does not have authority to override decisions within agency discretion when that discretion is exercised in good faith and in accordance with law." *Mann Media, Inc. v. Randolph County Planning Bd.*, 356 N.C. 1, 565 S.E.2d 9 (2002). "The 'arbitrary or capricious standard is a difficult one to meet. Administrative agency decisions may be reversed as arbitrary or

capricious if they are 'patently in bad faith,' [*Burton v. City of Reidsville*, 243 N.C. 405, 407, 90 S.E.2d 700, 702 (1956),] or 'whimsical' in the sense that "they indicate a lack of fair and careful consideration' or 'fail to indicate [] any course of reasoning and the exercise of judgment. []' *[State ex rel.] Comm'r of Ins. v. [N.C.] Rate Bureau*, 300 N.C. [381,] 420, 269 S.E.2d [547,] 573 [(1980)]." *Lewis v. N.C. Dep't of Human Resources*, 92 N.C. App. 737, 740, 375 S.E.2d 712, 714 (1989).

16. Petitioner has not carried the burden of demonstrating that DMA's decision was not exercised in good faith or in accordance with the law.

17. *Zamani v. Bremby*, 2012 Conn. Super. LEXIS 1295 (Conn. Super. Ct. May 16, 2012) is not binding on this tribunal. In that case, the court dismissed plaintiffs' claims for money damages and retroactive injunctive and declaratory relief, but allowed plaintiffs' claims for prospective declaratory and injunctive relief to go forward, specifically finding that "The court, of course, has decided only that plaintiffs have made a 'substantial allegation' of a regulatory violation. The court has not decided whether the plaintiffs can prove or have proved these allegations." Petitioner's argument that a North Carolina court must rely on the good cause exception as a basis for lifting a suspension is not supported by *Zamani*.

18. Petitioner did not present any evidence which demonstrated that DMA did not review all of the considerations set forth in 42 CFR § 455.23(e).

19. Petitioner has not met his burden of showing by a preponderance of the evidence that he is the sole community physician for specialized services in multiple communities, or that he serves a large number of recipients in medically underserved areas.

20. Petitioner did not present any evidence demonstrating that, since his initial payment suspension, he has attempted to acquire the appropriate site-specific Medicaid Provider Number from the State Medicaid agency necessary to provide his services in medically underserved areas outside of Wake County. Without a Medicaid Provider Number for any alternate service locations, it is not feasible for Respondent to determine where Petitioner provided the services he claims.

21. Petitioner has not met his burden of showing that DMA or the Hearing Officer's decision in this matter was erroneous, failed to use proper procedure, arbitrary or capricious, or contrary to law or rule.

22. Pursuant to N.C.G.S. § 150B-34, based upon the preponderance of the evidence and "giving due regard to the demonstrated knowledge and expertise of the agency with respect to facts and inferences within the specialized knowledge of the agency," the Undersigned finds that Respondent DMA did not act erroneously, fail to use proper procedure, act arbitrarily or capriciously, or fail to act as required by law or rule when it suspended payments to Petitioner enrollment in accordance with 42 C.F.R. §455.23.

DECISION

NOW, THEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, it is decided that Respondent's decision to suspend payments to Petitioner should be affirmed.

NOTICE

The agency making the final decision in this contested case shall adopt the Decision of the Administrative Law Judge unless the agency demonstrates that the Decision of the Administrative Law Judge is clearly contrary to the preponderance of the admissible evidence in the official record. The agency is required to give each party an opportunity to file exceptions to this Decision issued by the Undersigned, and to present written arguments to those in the agency who will make the final decision. N.C.G.S. §150B-36(a).

In accordance with N.C.G.S. §150B-36, the agency shall adopt each finding of fact contained in the Administrative Law Judge's decision unless the finding is clearly contrary to the preponderance of the admissible evidence, giving due regard to the opportunity of the Administrative Law Judge to evaluate the credibility of witnesses. For each finding of fact not adopted by the agency, the agency shall set forth separately and in detail the reasons for not adopting the finding of fact and the evidence in the record relied upon by the agency. Every finding of fact not specifically rejected as required by Chapter 150B shall be deemed accepted for purposes of judicial review. For each new finding of fact made by the agency that is not contained in the Administrative Law Judge's decision, the agency shall set forth separately and in detail the evidence in the record relied upon by the agency establishing that the new finding of fact is supported by a preponderance of the evidence in the official record.

The agency that will make the final decision in this case is the North Carolina Department of Health and Human Services. This agency is required by N.C.G.S. §150B-36(b) to serve a copy of the final decision on all parties and to furnish a copy to the parties' attorneys of record and to the Office of Administrative Hearings.

IT IS SO ORDERED.

This is the 5th day of September, 2012.

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Fred G. Morrison Jr.
Senior Administrative Law Judge