# STATE OF MICHIGAN

# COURT OF APPEALS

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| MARK L. SILVERMAN, M.D.,<br><br>Plaintiff-Appellant, | UNPUBLISHED<br>July 22, 2003 |
| v<br><br>DIRECTOR OF MICHIGAN DEPARTMENT OF COMMUNITY HEALTH and MICHIGAN DEPARTMENT OF COMMUNITY HEALTH, f/k/a DEPARTMENT OF SOCIAL SERVICES,<br><br>Defendants-Appellees.[1] | No. 236473<br>Oakland Circuit Court<br>LC No. 00-021237-AA;<br>96-526413-AA |

Before: Murray, P.J., and Neff and Talbot, JJ.

PER CURIAM.

We granted leave in this case to review the trial court's orders affirming defendants' final administrative decision, finding plaintiff jointly and severally liable with plaintiff's former employer, Psychological Services of Michigan, P.C. (PSM), for repayment of $142,560.17 in Medicaid overpayments made by defendant Michigan Department of Community Health (MDCH). We reverse on the basis of an incorrect interpretation of the applicable statute.

I. Basic Facts and Procedural History

The relevant facts are not in dispute. Plaintiff is a psychiatrist. In 1991, while in his residency, plaintiff entered into a verbal consulting contract with PSM, where he was hired part-time and paid $125 an hour for his services. In connection with his employment with PSM, plaintiff completed a MDCH Medical Assistance Enrollment Agreement, which allowed PSM to use plaintiff's provider number to submit claims and receive payment directly for eligible Medicaid claims. The agreement stated that PSM and plaintiff "agreed to be jointly and severally liable for any overpayments billed and paid . . . ." Between 1991 and 1993, PSM billed the program $142,560.17, using plaintiff's provider number. A review of the records revealed that the billings were for services plaintiff did not provide and it was determined that PSM submitted fraudulent claims using plaintiff's provider number without plaintiff's knowledge. The claim forms at issue did not contain plaintiff's signature. Rather, the claim forms had

[1] Unless otherwise indicated, defendants-appellees will be collectively referred to as "defendants."

plaintiff's name typed on them. It is undisputed that plaintiff had no knowledge of the false claims submitted by PSM under his provider number.

Defendants sought repayment from both plaintiff and PSM for the above amount of benefits paid. Plaintiff challenged the action and brought a contested case hearing before defendant MDCH. Following a hearing, defendant MDCH director issued an order, adopting the findings of fact and conclusions of law made by the MDCH hearing referee and concluding that plaintiff and PSM were jointly and severally liable for the repayment of the $142,560.17 in overpayments. Plaintiff appealed the decision and the circuit court remanded the matter to allow for the taking of additional evidence. After receiving the additional evidence on remand, the hearing referee recommended adoption of its original decision. In its final decision, defendant MDCH upheld the decision requiring plaintiff to repay the $142,560.17 in Medicaid overpayments.

Plaintiff again appealed to the circuit court, seeking review of defendants' determination that he was responsible for the Medicaid overpayments when the payments were made to his employer based on fraudulent billing records submitted by a third-party without his certification or knowledge and despite the fact that he did not provide the services or receive payment for the claims. The circuit court affirmed the final decision of the MDCH, finding on the record that:

> [A]lthough respondent had the option of seeking repayment from only PSM pursuant to MCL 400.111(a)(15) [sic] respondent also had the authority to seek repayment against the petitioner. . . . The Court further finds the certification in this case was proper since pursuant to MCL 400.111(17)(b) [sic] certification by someone other than the provider requires only an indelible mark. An indelible mark is a mark that cannot be removed or erased . . . . In other words, a typed name is sufficient. Finally, the Court finds that the application of the Social Welfare Act in this case did not violate the substantive due process clause which requires only that administrative agency standards be reasonably precise . . . .
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> The Court finds that the statute at issue in this case clearly state [sic] the potential for joint and several liability for participating providers. Finally, the Court finds the petitioner has failed to show how any delays caused by the respondent have prejudiced him or otherwise effected [sic] the outcome of the case.

Thereafter, plaintiff moved for reconsideration, which the circuit court denied.[2] This appeal by plaintiff followed.

## II. Standard of Review

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[2] In the opinion denying plaintiff's motion for reconsideration, the circuit court noted that it incorrectly applied the language in MCL 400.111b(17)(a), but found that reconsideration of the facts of this case under MCL 400.111b(17)(b) resulted in the same conclusion because it provided for certification by the indelible written name of the provider.

When reviewing a lower court's review of an administrative agency decision, this Court must "determine whether the lower court applied correct legal principles and whether it misapprehended or grossly misapplied the substantial evidence test to the agency's factual findings." *Boyd v Civil Service Comm*, 220 Mich App 226, 234; 559 NW2d 342 (1996). This standard of review is indistinguishable from the clearly erroneous standard of review. *Id.* A finding is clearly erroneous when, on review of the whole record, this Court is left with a definite and firm conviction that a mistake has been made. *Id.* at 235. At the same time, this appeal involves the interpretation or construction of a statute, which is a question of law that this Court reviews de novo. *Christiansen v Gerrish Twp*, 239 Mich App 380, 384; 608 NW2d 83 (2000).

## III. Analysis

Plaintiff argues on appeal that the circuit court misinterpreted the conditions for holding plaintiff jointly and severally liable for the repayment of fraudulently billed Medicaid funds under MCL 400.111b(17). Plaintiff asserts that because the claim forms in this case did not contain his signature or the name of the person signing his name, the statutory certification requirements were not met, thereby relieving him of any liability. Thus, the question presented on appeal is whether, under the Social Welfare Act, MCL 400.1 et seq., a Medicaid provider may be held jointly and severally liable for repayment of funds where the provider's employer fraudulently submitted claims for services using the provider's number but without the requisite certification to indicate that the provider certified the claim. We hold that the circuit court misinterpreted the statute in finding plaintiff jointly and severally liable for the Medicaid overpayments.

The primary goal of statutory interpretation is to ascertain and give effect to the intent of the Legislature. *Frankenmuth Mut Ins Co v Marlette Homes, Inc*, 456 Mich 511, 515; 573 NW2d 611 (1998) (citations omitted). The first step in determining the Legislatures intent is to examine the specific language of the statute itself. *In re MCI Telecommunications Complaint*, 460 Mich 396, 411; 596 NW2d 164 (1999). If the statutes language is clear and unambiguous, the court must apply the statute as written and judicial construction is neither necessary nor permitted. *Sun Valley Foods Co v Ward*, 460 Mich 230, 236; 596 NW2d 119 (1999); *Howard v Clinton Charter Twp*, 230 Mich App 692, 695; 584 NW2d 644 (1998). Nothing will be read into a clear statute that is not within the manifest intention of the Legislature as derived from the language of the statute itself. *Roberts v Mecosta Co General Hosp*, 466 Mich 57, 63; 642 NW2d 663 (2002). However, if reasonable minds could differ as to the meaning of a statute, judicial construction is permitted. *Howard, supra.* "A court must look to the object of the statute and the harm it was designed to remedy and apply a reasonable construction in order to accomplish the statute's purpose. Particular provisions should be read in the context of the entire statute to produce an harmonious whole." *ABC Supply Co v River Rouge*, 216 Mich App 396, 398; 549 NW2d 73 (1996) (citations omitted).

MCL 400.111a(7)(d) provides the director of the MDCH with the authority to "[r]ecover payments to a provider in excess of the reimbursement to which the provider is entitled. The department shall have a priority lien on any assets of a provider for any overpayment, as a consequence of fraud or abuse, that is not reimbursed to the department." At the same time, MCL 400.111b provides the requirements as conditions of participation by providers in the medical assistance program for the medically indigent. It states in pertinent part:

(16) A provider shall notify the director of a payment received by the provider to which the provider is not entitled or that exceeds the amount to which the provider is entitled. If the provider makes or should have made notification under this subsection or receives notification of overpayment under section 111a(17), the provider shall repay, return, restore, or reimburse, either directly or through adjustment of payments, the overpayment in the manner required by the director. Failure to repay, return, restore, or reimburse the overpayment or a consistent pattern of failure to notify the director shall constitute a conversion of the money by the provider.

(17) *As a condition of payment for services rendered* to a medically indigent individual, *a provider shall certify that a claim for payment is true, accurate, prepared with the knowledge and consent of the provider*, and does not contain untrue, misleading, or deceptive information. A provider is responsible for the ongoing supervision of an agent, officer, or employee who prepares or submits the provider's claims. *A provider's certification required under this subsection shall be prima facie evidence that the provider knows that the claim or claims are true, accurate, prepared with his or her knowledge and consent, do not contain misleading or deceptive information, and are filed in compliance with the policies, procedures, and instructions, and on the forms established or developed pursuant to this act.* Certification *shall* be made in the following manner:

(a) For an invoice or other prescribed form submitted directly to the state department by the provider in claim for payment for the provision of services, by an indelible mark by hand, mechanical or electronic device, stamp, or other means by the provider, or an agent, officer, or employee of the provider.

(b) For an invoice or other form submitted in claim for payment for the provision of services submitted indirectly by the provider to the state department through a person, sole proprietorship, clinic, group, partnership, corporation, association, or other entity that generates and files claims on a provider's behalf, by the *indelible written name* of the provider on a certification form developed by the director for submission to the state department with each group of invoices or forms in claim for payment. *The certification form shall indicate the name of the person, if other than the provider, who signed the provider's name.*

(c) For a warrant issued in payment of a claim submitted by a provider, by the handwritten indelible signature of the payee, if the payee is a natural person; by the handwritten indelible signature of an officer, if the payee is a corporation; or by handwritten indelible signature of a partner, if the payee is a partnership.

* * *

(27) An employer . . . shall enter into an agreement on a form prescribed by the department, in which, as a condition of directly receiving payment for services provided by its employee provider to a medically indigent individual, the employer agrees to all of the following:

> (d) To agree to be jointly and severally responsible with the employee provider for any overpayments resulting from the department's direct payment under this section. [Emphasis added.]

The circuit court affirmed defendants' final decision to hold plaintiff jointly and severally liable for the reimbursement of the Medicaid funds PSM fraudulently claimed based on the certification requirements of MCL 400.111b(17)(b). The court found that the indelible written name requirement was met by the typing of plaintiff's name on the claim forms. The court therefore concluded that defendants properly paid the claims, and as a result, plaintiff was liable for repayment. We find the trial court's decision unsustainable under the plain language of the statute and the facts of this case.

The parties agree that § (17)(b) applies in this case. It is undisputed that plaintiff did not sign the submitted claim forms. Rather, plaintiff's name was typed in the space designated for the provider's signature, which satisfies the requirement of an indelible written name in § (17)(b). Further, and more importantly, it is also undisputed that the claim forms lacked the name of the person who typed plaintiff's name on the claim forms, despite § (17)(b)'s requirement that "[t]he certification form *shall* indicate the name of the person, if other than the provider, who signed the provider's name." (Emphasis added.) It is well settled that the term "shall" denotes a mandatory rather than a discretionary action, requiring compliance with its directions. *Roberts supra* at 65. Accordingly, under the plain and unambiguous language of the statute, the absence of the name of the person who affixed plaintiff's typewritten name onto the form fails to satisfy the certification requirement of MCL 400.111b(17)(b). Therefore, defendants improperly paid the submitted claims because certification was an expressed condition precedent to payment of the claims. MCL 400.111b(17).[3] Because we have concluded that the claims should not have been paid in the first instance without the proper certification attesting that a claim for payment is "true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue, misleading, or deceptive information," plaintiff cannot be held jointly and severally liable. Accordingly, the trial court erred in holding plaintiff liable for the overpayments.[4]

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[3] Defendants' argument that the certification requirement was waived because it is impracticable for the Medicaid payment program to individually review each claim form for a typed or handwritten signature is irrelevant to the analysis. The plain and unambiguous language of § (17) requires, "[a]s a condition of payment for services rendered to a medically indigent individual," certification that "a claim for payment is true, accurate, [and] prepared with knowledge and consent of the provider . . . ." MCL 400.111b(17).

[4] Nonetheless, as defendants argue and the trial court noted, 42 USC 1395f, the federal statute regarding certification requirements for Medicare payments, allows for a waiver of certification as a condition precedent for payment under the following limited circumstances:

> (a) Except as provided in subsections (d) and (g) of this section and in section 1395mm of this title, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc of this title and only if --

(continued…)

Defendants argue that plaintiff is liable for the overpayments because the provisions of MCL 400.111b, the provider enrollment agreement, and the policy manual impose a duty on plaintiff to ensure that the claims submitted under his provider number are accurate. Indeed, MCL 400.111b(17) states, in pertinent part, that "[a] provider is responsible for the ongoing supervision of an agent, officer, or employee who prepares or submits the provider's claims." Additionally, MCL 400.111b(27)(d) and the enrollment agreement signed by plaintiff require the employer and the provider to agree to be jointly and severally responsible for any overpayments billed and paid. Thus, we recognize that by signing the enrollment agreement, plaintiff agreed to be held jointly and severally liable for any overpayments.

However, as plaintiff points out, these statutory and contractual provisions assume that the submitted claims are for services rendered or ordered by the provider or under his supervision. See e.g., MCL 400.111b(23). In fact, the plain language of MCL 400.111b(17) itself begins: "As a condition for payment *for services rendered* to a medically indigent individual," the provider shall certify the claim. (Emphasis added.) Similarly, MCL 400.111b(27), a provision relied on by defendants, requires joint and several responsibility for employers and employee providers for "services provided by its employee provider." Likewise the enrollment agreement provides that the employer can bill "for services provided by the applicant to eligible recipients," and receive payment "for services billed and paid for eligible recipients." Here, it is undisputed that plaintiff did not provide or order any of the services billed in the claims submitted under plaintiff's provider number, nor did he have any knowledge of such claims or payments. Further, the contractual obligations between PSM, plaintiff, and defendants were limited in scope to PSM billing and receiving payment "for Medical assistance Program services *provided* by the applicant[/provider] to eligible recipients." (Emphasis added.) Thus, holding plaintiff liable under the facts of this case for the fraudulent actions of PSM outside both the scope of the contractual agreement and the duty imposed on plaintiff under MCL 400.111b(17), is an incorrect interpretation of the law. Accordingly, the trial court's order affirming defendants' final decision finding plaintiff jointly and severally liable with PSM for repayment of the $142,560.17 defendants paid to PSM on the basis of fraudulently submitted and uncertified claims is reversed.

Due to the above resolution of the issue, plaintiff's remaining arguments need not be addressed.

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(…continued)

> (1) written request, signed by such individual, *except in cases in which the Secretary finds it impracticable for the individual to do so*, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary by regulation prescribe . . . . [Emphasis added.]

However, the plain language of 42 USC 1395f provides that certification may be waived when it is impracticable for the *individual*, i.e. the provider, as determined by the Secretary, not when it is impracticable for defendants. On the record before us, there is no evidence that defendants made a determination that plaintiff was not required to certify the claim forms submitted under his provider identification number. Therefore, defendants did not waive the certification requirements, and the provisions of 42 USC 1395f are inapplicable.

Reversed.

/s/ Christopher M. Murray
/s/ Janet T. Neff
/s/ Michael J. Talbot