State of Michigan Health Care License Investigations and the Collateral Effects of Licensing Sanctions

by Robert S. Ivey

This article will provide readers with an overview of the typical process involved in the investigation and prosecution of Michigan licensed health care providers for alleged violations of Michigan’s Public Health Code and the collateral legal effect that imposed sanctions can have upon these health care providers.

An Overview of the Bureau of Health Professions
Prior to December 7, 2003, investigations into, and resulting disciplinary actions against, Michigan licensed health care providers fell within the purview of the Bureau of Health Services’ under the Michigan Department of Consumer & Industry Services (MDCS). In accordance with Executive Order 2003-18, the Bureau of Health Services became the Bureau of Health Professions (BHP) and, along with the Bureau of Health Systems, transferred its operations from the MDCS to the Department of Community Health (MDCH), effective December 7, 2003. In 2011, in accordance with Executive Order 2011-04, both BHP and the Bureau of Health Systems transferred their operations from the MDCH to the Department of Licensing and Regulatory Affairs (LARA), effective April 24, 2011. On October 18, 2012, LARA announced the creation of the new Bureau of Health Care Services (BHCS). The new BHCS brought together the Bureau of Health Systems, which governs licensed health care entities such as hospitals and ambulatory surgical centers, and the BHP, which governs individual licensed and registered health care providers such as physicians and nurses, under one umbrella for purposes of consolidating resources and administrative efficiency. At the time of this article, the consolidation has not been completed and there have not been any substantive changes to the policies and procedures affecting licensed health care providers. As such, the remainder of this article shall reference the BHP as opposed to the new BHCS. The BHP regulates more than 410,000 health professionals in Michigan who are licensed, registered or certified under Articles 6, 7, and 15 of the Michigan Public Health Code (MPHC) and 42 Code of Federal Regulation (CFR) Part 483. The mission of the BHP is to protect the health, safety and welfare of the citizens of Michigan by ensuring that providers of health services meet required standards of practice. This is done through the administration of the occupational regulation sections of the MPHC, Public Act 368 of 1978, as amended, and by addressing practice issues related to health care in Michigan.

The BHP licenses and registers 37 health care occupations in 26 different health care professions. Additionally, the BHP receives and investigates allegations against these professionals. Regulatory discipline is usually a function of a licensing board or task force within the BHP that is composed of both professional and public members appointed by the governor. The BHP is structured into four divisions: the Administration Division, Licensing Division, Regulatory Division, and the Investigation Division, and is charged with the responsibility of licensing and regulatory activities.

A Description of the Investigatory Process
The BHP distinguishes between allegations filed by consumers and others and formal complaints filed by the state. An allegation is a type of consumer complaint filed with the BHP. The consumer alleges that a violation of the MPHC has occurred. The allegation must be submitted in writing, contain the name and contact information of the person making the allegation, the name and profession of the licensee, a detailed description of the alleged problem or incident, and the names and contact information of any potential witnesses. Anonymous allegations will typically not be processed. Typical allegations are for quality-of-care concerns, a scope-of-practice concern issue or the conduct of the licensee — which may include potential criminal conduct (e.g., a patient who is billed for services that he...
or she never received may submit a written allegation for same to the BHP). After receiving an allegation, the BHP reviews it and determines whether the allegation is within its jurisdiction to act on it (e.g., if it involves a simple fee dispute, it will not be deemed outside the scope of the BHP). If the allegations are within the jurisdiction of the BHP, the BHP will forward the allegations to a representative of the applicable board (e.g., if the allegation pertains to a nurse, a representative of the Board of Nursing will be consulted) for the determination of whether an investigation is warranted. In addition to allegations filed by consumers, the BHP may also receive written notice of any of the following circumstances, often in accordance with one or more state and/or federal statutes requiring certain individuals and entities to report such circumstances to the BHP: (i) a limitation of staff privileges or a change in employment status due to disciplinary action taken by a health facility or agency; (ii) a disciplinary action taken by a professional health society; (iii) an adverse medical malpractice settlement, award or judgment; (iv) a felony conviction; (v) a misdemeanor conviction punishable by up to two years of imprisonment or that involves alcohol or a controlled substance; (vi) a licensee’s ineligibility to participate in a federally funded health insurance or health benefits program; (vii) a report by a licensee that another licensee has committed a violation of the MPHC; or (viii) a disciplinary action by a licensing board in another state. A licensee must notify LARA of a criminal conviction or a disciplinary licensing action taken by another state against the licensee within 30 days after the date of conviction or disciplinary action (regardless if it’s on appeal), which will likely lead to an immediate investigation by the bureau. A licensee’s failure to do so gives rise to an independent disciplinary action under the MPHC.

An investigation into an allegation is conducted by the Investigation Division and usually involves interviewing the person filing the allegation, interviewing the licensee, identifying and interviewing other persons such as coworkers or employers who may provide relevant information, and collecting other evidence.

**Bases for the Issuance of an Administrative Complaint**

If the BHP believes that there is sufficient evidence to demonstrate a violation of the MPHC, a formal administrative complaint will be issued on behalf of the BHP against the licensee charging the licensee with specific violations of the MPHC. MCLA §333.16221 sets forth the numerous bases for the issuance of an administrative complaint. The most commonly used bases are MCLA §§333.16221(a), (b) (i) and (b)(vi). MCLA §333.16221(a) is cited as a basis due to “a violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition that impairs, or may impair, the ability to safely and skillfully practice the health profession.” MCLA §333.16221(b)(i) is cited as a basis due to “incompetence.” MCLA §333.16221(b)(i) is cited as a basis due to “lack of good moral character.”

Amongst the numerous grounds for issuance of an administrative complaint, the MPHC provides that the BHP may issue an administrative complaint due to certain preceding criminal violations. For example, a conviction of: a misdemeanor punishable by imprisonment for a maximum term of two years; a misdemeanor involving the illegal delivery, possession, or use of a controlled substance; any felony; an any criminal sexual conduct; reckless or intentional inappropriate destruction or alteration of medical records; a misdemeanor or felony involving fraud to obtain professional fees; a misdemeanor related to the ability to practice safely/competently; and practicing under the influence of alcohol or drugs all provide a basis for a licensing action against the convicted licensee.

**Issuance of the Administrative Complaint & Summary Suspension**

When the administrative complaint is issued, a summary suspension may also be issued. If the BHP believes that there could be an immediate risk to the public health, safety or welfare, it may order a summary suspension of the license until an administrative hearing is held. If the licensee is convicted of a felony, a misdemeanor punishable
by two years or more in prison, or a misdemeanor involving the illegal delivery, possession or use of a controlled substance, the BHP will summarily suspend the licensee’s license, regardless of whether there is such an immediate risk.13 The suspension will remain in place until the administrative hearing, if requested, is concluded unless otherwise resolved through a petition to LARA for an immediate hearing before an administrative law judge (ALJ) to dissolve the summary suspension order.14

Compliance Conference and Settlement Conferences

After the issuance of an administrative complaint and filing of an answer thereto, a compliance conference and/or a settlement conference may be held to attempt to reach a resolution of the complaint short of attending a formal administrative hearing. Any proposed settlement between the BHP and the licensee must be approved by the disciplinary subcommittee of the applicable licensing board. A compliance conference is an informal meeting typically between the health care licensee, his or her attorney, and an analyst from the BHP. On occasion, when available and/or upon request, a designated representative of the licensee’s respective board (referred to as the “conferree”) may also attend the compliance conference. At the compliance conference, the health care licensee is given an opportunity to demonstrate his or her compliance with the applicable provisions of the MPHCs alleged to have been violated in the administrative complaint. The meeting is informal and there are no sound or video recordings or statements taken under oath. At, or shortly after, the compliance conference, the BHP confers with the conferree and then communicates any available settlement offers to the licensee or the licensee’s legal counsel for consideration. While not expressly provided for by statute or administrative rule, if the matter is not resolved via a compliance conference, there may be opportunities to resolve the matter short of a formal administrative hearing via a settlement conference held between the assistant attorney general (AAG) assigned to the matter and the licensee’s legal counsel.

Consent Orders

If a proposed settlement is reached between the BHP and/or the AAG, the licensee and the conferee, such settlement is reduced to a written, proposed consent order and stipulation (COS)15 that is drafted by the BHP and/or the AAG. While most of the language of the proposed COS is standard, attorneys for the licensee can negotiate certain language to the benefit of the licensee. Importantly, the COS is not final until it is approved by the disciplinary subcommittee of the applicable licensing board. Typically, such approval is sought at the next regularly scheduled meeting of that subcommit-

Elizabeth Hardy Is Inducted Into The American College Of Trial Lawyers

Our colleague and Oakland County Bar Association member Elizabeth Hardy was recently inducted as a Fellow of the American College of Trial Lawyers during a ceremony in New York City. Ms. Hardy is one of only 97 attorneys in Michigan to have received this honor since this prestigious organization was founded in 1950.

The College is composed of the best of the trial bar from the United States and Canada. Fellowship is extended by invitation only, after careful investigation, to those experienced trial lawyers who have mastered the art of advocacy and whose professional careers have been marked by the highest standards of ethical conduct, professionalism, civility, and collegiality. Membership of the College may not exceed one percent of a State Bar’s membership.

A founding member of Michigan’s top-rated management-side employment and labor practice, Ms. Hardy is among the most skilled and respected litigators and appellate lawyers in the field. She and her firm have defended many complex high-profile jury trials to winning verdicts, and her appellate practice has significantly influenced the substantive development of Michigan employment law. Her practice specialties include: defending discrimination, harassment, retaliation, ADA, FMLA, and FLSA claims; employment and executive contracts; non-competition and trade secrets; and employment-based tort issues.

Congratulations, Liz, on this well-deserved honor.
Each licensing board publishes its schedule of annual meetings online. Most licensing boards meet every other month. Members are not permitted to attend any committee meetings without being formally nominated and/or if the licensee has not been formally nominated and received a waiver from the appropriate licensing board. The committee seeks to address any questions or concerns that arise during its meeting.

Although the meeting of the disciplinary committee is a public meeting and can be attended by the licensee and/or the licensee’s legal counsel, neither the licensee nor the licensee’s legal counsel will be provided with an opportunity to argue the matter or introduce any information in an attempt to influence the disciplinary committee’s decision. The disciplinary subcommittee can accept, modify, or reject the terms and conditions of the proposed COS. If the disciplinary subcommittee accepts the COS as written, it is signed and becomes effective in accordance with the terms of the COS, which will remain in effect until it is rescinded.

The sanctions and conditions of the proposed COS, the BHP and/or AAG notifies the licensee of the proposed modifications. If the disciplinary subcommittee modifies any of the terms and conditions of the proposed COS, the BHP and/or AAG notifies the licensee of the proposed modifications. If the disciplinary subcommittee modifies any of the terms and conditions of the proposed COS, the BHP and/or AAG notifies the licensee of the proposed modifications. If the disciplinary subcommittee modifies any of the terms and conditions of the proposed COS, the BHP and/or AAG notifies the licensee of the proposed modifications.
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The Department of Community Health (which reports
disciplinary actions to licensed health care facilities and
agencies), state and federal agencies responsible for fiscal
administration of health care programs, applicable
professional associations, the Associated Press (AP) and
the United Press International (UPI). LARA also provides
the State of Michigan Library with an annual report of all
disciplinary actions within a preceding three years and
provides the National Practitioner Data Bank with a list of
disciplined licensees.

The Collateral Effect of Licensing Sanctions upon
the Licensee

The severity of the sanction imposed by the disciplinary
subcommittee will determine the extent of the collateral
damage to the licensee. This is a list of some, but not all, of
the repercussions that a sanctioned licensee may encounter:

- Loss of Hospital Privileges: Typically, in
accordance with medical staff bylaws at a hospital,
a licensee whose license has been revoked or suspended
will lose his or her clinical privileges revoked or suspended for at least the term of the
sanction. Similarly, a licensee whose license has been revoked will often have his or her clinical privileges restricted if they fall within the
governance of the hospital’s bylaws, the hospital’s due process procedures, or the
hospital’s medical staff bylaws. A hospital may summarily or automatically suspend the
licensee’s clinical privileges prior to any hearing on the matter. When a licensee’s clinical
privileges at a hospital are affected, due process
is often afforded the licensee in accordance with the
hospital’s fair-hearing procedures. Provisions in
the hospital’s credentialing procedures manual,
hospital bylaws and medical staff bylaws are
often implicated and should be reviewed as well.

- Judicial review of clinical privileges at a private hospital was essentially
unavailable under Michigan law in the absence of allegations of discrimination or violations of state or federal law. Michigan law was
changed more than 20 years ago to authorize, reprimand, placed on probation or ordered to pay restitution, the
licensee must notify his or her employer and any hospital where he or she practices.

In addition to disclosures by LARA and the applicable professional board, a licensee has a duty to self-report in certain circumstances. If a licensee is
disciplinary action taken effect date and the

general nature of the complaint. This information is
available online at http://www.michigan.gov/healthlicensure
and is also available in writing from LARA.

In addition to publishing the DAR, LARA also notifies the Office of the Commissioner of Insurance Regulation (ORIR) (which provides the information to
insurance carriers providing professional liability insurance),
et al.,18 upholding the abrogation of the judicial non-intervention doctrine and a licensee’s right to challenge a private hospital staffing decision in court.

2. Loss of Participation and Enrollment with State Professional Associations: Professional associations will vary in their response to a sanctioned member, although it is unlikely that a licensee will be departicipated due to the imposition of a fine or reprimand. On the other hand, a licensee whose license has been revoked or suspended for a lengthy period of time will usually lose his or her membership in the association (e.g., Michigan State Medical Society). Typically, a licensee must maintain his or her membership in the professional association in order to continue to qualify for group health care insurance originally obtained through the professional association. Thus, departicipation from a professional association may have significant ramifications for the sanctioned licensee. In addition, there are some professional associations that obtain reduced premiums for professional liability insurance for its group members. Such malpractice insurance may be affected by a state-imposed sanction.

3. Loss of Participation in Preferred Provider Organizations (PPOs): While PPOs vary in their reaction to licensing sanctions, many PPOs have very strict policies regarding sanctions, often departicipating sanctioned licensees who have been reprimanded or placed on probation and not just those whose licenses have been revoked or suspended. While quality-of-care concerns will certainly lead to investigation and possible departicipation, sanctions having nothing to do with quality-of-care concerns are often cited as the basis for departicipation. PPOs have justified such departicipations as administrative cost savings, elimination of redundant services and other business reasons. Judicial review of such departicipation is available, although one must often exhaust internal, administrative remedies within the PPO first. Legal challenges to such departicipation may be based upon numerous legal theories including but not limited to: (a) violation of public policy, (b) breach of provider contract, (c) breach of implied covenant of good faith and fair dealing, (d) due process violations, (e) tortious interference with business expectations and/or contract, (f) violation of unfair competition laws, (g) violation of antitrust laws, (h) breach of third-party beneficiary contracts, and (i) breach of fiduciary duty.

4. Loss of Enrollment with Third-Party Payors: Like PPOs, third-party payors vary in their reaction to licensing sanctions, although the reaction tends not to be as severe as with the PPOs. Commercial carriers vary in their: responses but often will follow departicipation policies similar to BCBSM’s Traditional Program. BCBSM’s Traditional Program has set policies by which it determines whether departicipation is appropriate and, if so, the length of the departicipation period. At present, there are 13 non-exclusive departicipation criteria, which include termination or suspension of licensure, certification, registration, certificate of need or accreditation in Michigan. However, it is important to note that BCBSM may departicipate licensees who have lesser sanctions imposed upon them as well. For example, criterion number 13 provides for departicipation of providers who violate any local, state or federal regulation, law or code (which includes the MPHC), regardless of whether any sanction is imposed by the state for such violation. BCBSM’s Blue Preferred Plan (Trust) Program Professional Provider Agreement does not reveal any provision mandating termination from its network for licensing sanctions but does provide that the agreement may be terminated by BCBSM immediately at BCBSM’s option if a trust provider’s license is revoked, restricted or suspended.
5. Loss of DEA Registration: LARA will report to the U.S. Department of Justice when it revokes or suspends a provider's DEA license. A provider's DEA license may be suspended or revoked if the provider engages in any conduct that poisons the trust, confidence, or good faith of the DEA or the U.S. attorney general. A provider's DEA registration may be denied, revoked, suspended, or otherwise not in effect as a result of, or in connection with, a state licensing agency action. The effect of the revocation of a DEA registration may be for any items or services furnished by an excluded provider or directed or prescribed by an excluded provider, regardless of the method of reimbursement or to whom the payment is made. Likewise, no payment can be made for administrative and management services not directly related to patient care, professional services provided by an excluded provider. In addition, no federal program payment may be made to cover an excluded provider's salary, expenses, insurance, or to provide items or services furnished by an excluded provider does not provide direct patient care. An excluded provider cannot avoid the effect of such exclusion by changing from one health care profession to another.

6. Loss of Board Certification: A licensee whose license has been revoked or suspended for a lengthy period of time may not seek board certification in his or her field of specialty depending upon the rules and requirements of the governing board. Such loss of board certification could result in loss of clinical privileges in accordance with the entity's medical staff bylaws that require such certification in order to practice at the entity.

7. Exclusion from Participation with Medicare, Medicaid, and Other Federal and State Health Care Programs: There are basically two types of exclusion under the federal statutory and regulatory provisions for federal programs (e.g., Medicare and Medicaid) participation: mandatory exclusion and permissive exclusion. A criminal conviction related to the delivery of an item or service under the Medicare program or any state health care program (e.g., Medicaid) will result in a mandatory exclusion of at least five years. However, a provider whose license has been revoked or suspended or has otherwise lost his or her license for reasons bearing on the individual's professional competence, professional performance or financial integrity may be excluded from participating in Medicare and Medicaid at the discretion of the secretary of HHS. Likewise, the secretary of HHS has discretion to exclude a provider who has rendered his or her services under the Medicare program in violation of a formal disciplinary proceeding concerning the provider's professional competence, professional performance or financial integrity. The duration of a permissive exclusion resulting from a licensing sanction will be for a period of time not less than the period during which the provider's license is revoked, suspended or otherwise not in effect as a result of, or in connection with, a state licensing agency action. The effect of exclusion from the Medicare program will be for any items or services furnished by an excluded provider or directed or prescribed by an excluded provider, regardless of the method of reimbursement or to whom the payment is made. Likewise, no payment can be made for administrative and management services not directly related to patient care, professional services provided by an excluded provider. In addition, no federal program payment may be made to provide items or services furnished by an excluded provider or directed or prescribed by an excluded provider does not provide direct patient care. An excluded provider cannot avoid the effect of such exclusion by changing from one health care profession to another.

8. Exclusion from Participation in Commercially Available Health Care Plans: A claim for reimbursement for services furnished by an excluded provider may be submitted, a claim for reimbursement to Medicare/Medicaid may be subject to a civil monetary penalty of $10,000 for each claim plus treble damages. In addition, the excluded provider could jeopardize his or her ability for reinstatement into the Medicare/Medicaid programs in the future. Importantly, health care providers who employ or enter into contracts with excluded providers or provide items or services to Medicare/Medicaid beneficiaries may also be subject to civil monetary penalties and potential exclusion from the Medicare/Medicaid programs if they submit claims for items or services furnished by an excluded provider who they knew or should have known was excluded. According to the Office of Inspector General, providers and contracting entities have an affirmative duty to check the program exclusion status of their suppliers and contractors to ensure that they are not employing excluded providers. If a health care provider is found to be employing excluded providers, the provider may be subject to civil monetary penalties and exclusion.

Practical Tips to Avoid a Licensing Action

Having a license to practice health care in the state of Michigan is not a right but a privilege that can be taken away or restricted for failing to abide by various statutory bases set forth in the Michigan Public Health Code ("MPHC"). As such, compliance with the MPHC is the key to avoiding a licensing action. In order to facilitate such compliance, the MPHC provides a licensing licensees to...
in facilitating compatibility, emphasis should be placed on conducting internal monitoring and auditing, as this can help identify a previously unknown issue and provide one with patient care, preventive measures to address the issue prior to the issue resulting in a licensing investigation.

In addition, emphasis must be placed on appropriately documenting any medical records. The majority of licensing actions are based, at least in part, upon a lack of appropriate documentation in the medical record. For example, states with exclusionary consequences for a licencsee's instructions, such non-compliance should be documented. If not, a subsequent review of the licensee's medical records may lead the reviewer to conclude that the licensee, not the patient, failed to follow up. Moreover, while there is no standard form utilized by all health care licensees for documenting patient encounters, incorporating the O.A.P. Format (Subjective, Objective, Assessment and Plan) for recording what the health care parther looks to see if each of these elements is present in the document. Importantly, as of December 2006, a health care licensee is required to maintain a record for each patient for whom he or she had provided medical services, including a full and complete record of tests and examinations performed, observations made and treatments provided.

Poor documentation, and meaningful use of electronic health records (EHR), health care licensees should be mindful of issues such as self-populating record fields that can result in significant inaccuracies in the medical record. For example, due to a self-populating field, the medical record may state in one area: “patient has no complaints of pain”, but in another area state: “patient presents with severe pain.” In some cases, EHR systems may automatically generate a prescription, including strength and form, based on the notes in the record. In such instances, the health care licensee must take care on two levels. Firstly, the licensee must ensure that the prescription generated by the EHR system is appropriate for the patient. The system is convenient in generating the prescription, nothing can substitute for the professional judgment of the licensee. Secondly, if the licensee does, in fact, change the EHR-system-generated prescription, the licensee must ensure that such alterations are reflected in the record. An additional test the licensee may use is that of challenging that the prescriptions were not authored by the licensee. In addition, the prescription must be reviewed by the health care provider for any back office errors. The pharmacy should be asked that on text note that next decision on refilling the prescription or prescribing another medication. Liability can also arise by missing simple spelling errors, despite step-by-step instructions, the error was with which certain tasks can be completed with an EHR system can result in increased carelessness where such mistakes could have much greater implications, including risks of patient safety, medical malpractice claims or audit activity – all which could lead to a licensing action.

Lastly, due to the growing epidemic in Michigan regarding health care licensees, the department has an increased interest in enforcing disciplinary standards through well-publicized guidelines.26 Although each of these elements plays a role

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**Feature Article**

5. Loss of DEA Registration: LARA will report to the U.S. Department of Justice when it revokes or suspends a provider’s license. 21 USC § 842 provides that provider’s DEA general permit or provider’s DEA registration, or revocation of a provider’s DEA registration, when the provider’s DEA registration or license is suspended, revoked, or when competent state authority has merely recommended that the provider’s state license or registration be suspended, revoked or denied. The provider may not be disciplined in order to contest such action. In cases where there is a perception of imminent danger to the public health or safety, the U.S. attorney general may immediately suspend a provider’s DEA registration or order any other hearing.

6. Loss of Board Certification: A licensee whose license has been revoked or suspended for a lengthy period of time, or for any other reason, may be excluded from or may not become eligible for inclusion in or held by any specialty board certification in his or her field of specialty depending upon the rules and requirements of the governing board. Such loss of board certification could result in loss of clinical privileges in accordance with the entity’s medical staff bylaws that require such certification in order to practice at the entity.

7. Exclusion from Participation with Medicare, Medicaid, and other Federal and State Programs: There are basically two types of exclusion under the federal statutory and regulatory provisions mentioned above: (1) the OIG (e.g., Medicare and Medicaid) program participation exclusion and permisive exclusion. A criminal conviction related to the delivery of an item or service under the Medicare program or any state health care program (e.g., Medicaid) will result in a mandatory exclusion of at least five years. However, a provider whose license has been revoked or suspended or has otherwise lost his or her license for reasons bearing on the individual’s professional competence, professional performance or financial integrity may be excluded from participating in Medicare and Medicaid at the discretion of the Secretary of HHS. Likewise, the Secretary of HHS has discretion to exclude a provider who has surrendered his or her license or certificate of registration or otherwise lost his or her license for reasons bearing on the individual’s professional competence, professional performance or financial integrity. The duration of a permission exclusion resulting from a licensing sanction will be for a period of time not less than the period during which the provider’s license is revoked, suspended or otherwise not in effect as a result of, or in connection with, a state licensing agency action.21

The effect of exclusion from the Medicare Medicaid program may be for any items or services furnished by an excluded provider or directed or prescribed by an excluded provider, regardless of the method of reimbursement or to whom the payment is made. Likewise, no payment can be made for administrative and management services not directly related to patient care for which an excluded provider participates in. In addition, no federal program payment may be made to cover an excluded provider’s salary, expenses, fringe benefits, even if the excluded provider does not provide direct patient care. An excluded provider cannot avoid the effect of such exclusion by changing from one health care profession to another. An excluded provider, however, may be permitted to submit claims for items or services furnished by an excluded provider who they knew or should have known was excluded. According to the Office of Inspector General, providers and contracting entities have an affirmative duty to check the program exclusions list maintained by the OIG (e.g., OIG.hhs.gov/). Health care providers may only employ an excluded provider in limited situations where the health care provider is both able to pay the individual exclusively with private funds or funds from other non-federal sources and separate and distinct from the services furnished by the excluded provider relate solely to non-federal programs.

**Practical Tips to Avoid a Licensing Action**

Having a license to practice health care in the state of Michigan is not a right but a privilege that can be taken away or restricted for failing to abide by various statutory bases set forth within the Michigan Public Health Code ("MPHC"). As such, compliance with the MPHIC is the key to avoiding a licensing action. In order to facilitate such compliance, the individual must:

1. Recognize that he or she is a licensed health care provider.
2. Be aware of an active compliance plan at his or her worksite. If the health care licensee is a solo provider or member of a group that does not have a complied with the requirements of the Michigan Public Health Code ("MPHC"). As such, compliance with the MPHIC is the key to avoiding a licensing action. In order to facilitate such compliance, the individual must:

- Be aware of an active compliance plan at his or her worksite.
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Online to request prescription data on patients ... [since]
using MAPS Online before and during treatment ... can
alert [the licensee] to any past ‘doctor shopping’ or ques-
tionable behavior.?” Health care licensees should not take
this “encouragement” lightly. BHP and law enforcement
have taken the position that the applicable standards of
care require physicians to perform MAPS queries regularly
on patients for whom they prescribe controlled substances
and that failure to do so is a breach of the applicable stan-
dard of care.

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He graduated with high distinction from the
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pro hac vice to various courts across the nation.

Footnotes
1 The authority of the Bureau of Health Services, now referred to as the Bureau of
Health Professions, is limited to granting licenses or registrations for the health care
professionals in Michigan and does not extend to fee disputes or personal conflicts
between patients and their health care providers.
2 These professions include: acupuncturist, athletic trainer, audiologist, chiropractic,
counseling, dentistry, dietetics and nutrition, marriage and family therapy, massage
therapy, medicine, nurse aide, nursing, nursing home administrator, occupational
therapy, optometry, osteopathic medicine, pharmacy, physical therapy, physician’s
assistant, podiatry, psychology, respiratory care, sanitation, social worker, speech-
language pathology and veterinary medicine.
3 In the case of Dep’t of Consumer Industry Services v. Shab, 236 Mich App 381, 600
NW2d 406 (1999), the court interpreted the statutory reporting requirement to only
apply to criminal convictions and disciplinary actions that occurred in a state other
than Michigan since the department already receives information from the clerk of
a court for criminal convictions under MCLA §769.16a. Nonetheless, the BHP has
taken a position that it disagrees with the court’s finding and will charge a health
care licensee under MCLA 333.1622(1)(b) for failing to make a report of a criminal
conviction that occurred in Michigan under MCLA §333.1622(3).
4 It should be noted that while the majority of administrative complaints are is-
sued directly from the BHP, some administrative complaints are issued from the
Michigan Attorney General’s Office (AG) on behalf of the BHP. For example, if an
allegation is complex and involves violations of the applicable standards of care
for that profession, it will often be referred by the BHP to the AG or if there are
other complaints already in process against a health care licensee, the matter may
be forwarded by the BHP to the AG for handling.
5 See MCLA §333.1622(b)(v).
6 Id.
7 Id.
8 See MCLA §333.1622(b)(vii).
9 See MCLA §333.1622(b)(viii).
10 See MCLA §333.1622(b)(ix).
11 See MCLA §333.1622(b)(xii).
12 See MCLA §333.1622(b)(xiii).
13 See Michigan Administrative Code R 338.1609.
15 If the conference recommends a dismissal of the administrative complaint, a COS
is unnecessary; however, the matter must still be approved by the disciplinary
subcommittee of the applicable licensing board.
16 It should be noted that in an unpublished opinion, the Michigan Court of Appeals
denied the argument that the administrative revocation of a physician’s license
based upon the physician’s previous misdemeanor conviction constituted multi-
ple punishment in contravention of federal double jeopardy protection (Dep’t of
Consumer & Industry Services v. Orzame, MD, 2001 WL 1545869 (2001)).
19 The secretary of HHS may take into consideration certain enumerated aggravat-
ing circumstances, which can lengthen the exclusionary period, as well as certain
everified mitigating factors, which may reduce the effect of such aggravating
circumstances.
20 These seven elements have been identified by the Office of Inspector General (OIG)
for the U.S. Department of Health and Human Services as key components of an
effective compliance program. For additional information on implementing these
components, see e.g., the OIG’s “Compliance Program Guidance for Individual
and Small Group Physician Practices.”
21 MCLA §333.1623(1).
22 MCLA §333.1622(1a).
23 MCLA §333.1622(b)(i).
25 http://www.michigan.gov/documents/mdch_pharmacyguidelinesusec-
span_139447_7.pdf.
Fishman, M.D., Michigan Department of Community Health, 2007. A copy may
be obtained by calling the Michigan Bureau of Health Professions Professional
Practice Section Office at (517) 335-6557.
27 http://www.michigan.gov/lara/0,4601,7-154-27417_55478_55485---,00.html.