No. 1-10-1534

SIXTH DIVISION
MAY 20, 2011

IN THE APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

MICHAEL B. FERNANDO, M.D.,	)	Appeal from the Circuit Court
	)	of Cook County
Plaintiff-Appellant,	)	
	)	
v.	)	
	)	09 L 050902
BARRY S. MARAM, Director, Illinois Department of Healthcare and Family Services, in his official capacity, and THE ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES,	)	
	)	Honorable
	)	James R. Epstein,
Defendants-Appellees.	)	Judge Presiding.

JUSTICE McBRIDE delivered the judgment of the court.
Justices Cahill and R.E. Gordon concurred in the judgment.

ORDER

HELD: The director of the Illinois Department of Healthcare and Family Services's decision to terminate plaintiff from the Illinois Medical Assistance Program and recover $639,008.99, in overpayments was not clearly erroneous.

Plaintiff Michael B. Fernando, M.D., appeals from the circuit court's order affirming the administrative decision of defendants, the Illinois Department of Healthcare and Family

Services[1] (Department) and its director, Barry S. Maram, in his official capacity, ordering plaintiff to return money improperly paid under his Medicaid provider number and terminating plaintiff from participation in the Illinois Medical Assistance Program (Medicaid program).

On appeal, plaintiff argues that: (1) the Department erred in finding him liable for the overpayments made under his provider number because (a) his former employer, Youth Empire Services (YES) was responsible for overbilling and received the payments, (b) his alternate payee agreement with YES was invalid because a valid power of attorney was not executed, (c) the Department should have been judicially estopped from asserting inconsistent positions regarding the alternate payee agreement, and (d) the Department violated plaintiff's due process rights by denying his request to join YES as a necessary party in the administrative proceedings; (2) the decision to terminate plaintiff from the Medicaid program was clearly erroneous; and (3) the Department's extrapolation of the audit results was not statistically valid where the sample failed to include the entire universe of claims.

On August 7, 1997, plaintiff enrolled in the Medicaid program by signing a provider agreement with the Department to provide psychiatric services to Medicaid recipients. As part of this participation agreement, plaintiff agreed "to comply with all current and future program policy provisions as set forth in the applicable Department of Public Aid Medical Assistance Program handbooks." Plaintiff also agreed "to bill the Department as stipulated in the applicable [handbooks] and not to bill the Department for any services rendered by another provider."

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[1] The Department of Healthcare and Family Services was formerly called the Department of Public Aid. Both titles will be referred to as the Department.

The provider agreement also included that plaintiff as the provider agreed:

> "to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or hard copy to the Department for payment. Furthermore, the provider agrees to review, affix an original signature, and retain in their files the Billing Certification which is the last page of the Remittance Advice. Any submittals of false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws."

The provider agreement further stated that,

> "Provider agrees to be fully liable to the Department for any overpayments which may result from the Provider's submittal of billings to the Department. The Provider shall be responsible for promptly notifying the Department of any overpayments of which the Provider becomes aware. The Department shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to the Department."

In February 1998, plaintiff entered into an employment relationship with YES as an agency psychiatrist. YES was a child welfare agency that provided counseling and other services to foster children. According to plaintiff, most of the children receiving services at YES were wards of the state. Naomi Jennings served as the chief executive officer (CEO) of YES. In April

1998, plaintiff became YES's director of medical services.

In February 1998, as part of plaintiff's employment, plaintiff executed an alternate payee agreement with Jennings, as a representative of YES. Under this agreement, YES would bill the Department for services provided by plaintiff to Medicaid recipients. An identical version of the alternate payee agreement was executed on May 1, 1998, between plaintiff and Jennings. The alternate payee agreement listed plaintiff's provider number as 036091786. It stated that plaintiff as the practitioner "shall be individually responsible for maintaining and making available to the Department all business and professional records sufficient to fully and accurately document the nature, scope, detail and receipt of services provided to public aid recipients." The alternate payee agreement further provided that "the practitioner retains full responsibility for any bills submitted in his name to the Department of Public Aid even though an alternate payee has been designated. This responsibility includes liability to repay any overpayments made by the Department." YES agreed to be jointly and severally liable with plaintiff for any overpayments.

While employed at YES, plaintiff also provided psychiatric services to other entities. Additional alternate payee agreements were executed with several of these entities for billing under the Medicaid program. Plaintiff left his employment with YES in June 2000 to begin a psychiatric practice in Peru, Illinois.

In May 2001, the Department notified plaintiff that it would be conducting an audit of billings for services to Medicaid recipients under his provider number for the period of December 1, 1998 to November 30, 2000. During the audit period, the Department paid bills

under plaintiff's provider number to 569 recipients, the universe of recipients. The audit looked at a random sample of bills for 234 of these recipients. The audit was based on the dates of payment, rather than the dates of service. The sample selection was based on the provider number without regard to location. The Department's initial audit revealed 6,525 discrepancies in the sample, which equaled a hard amount of $298,251.21. This amount was extrapolated to $674,490.22, for the universe.

Plaintiff requested a reaudit. The reaudit included a review of additional documents provided by plaintiff as well as the prior documentation. The reaudit showed that the Department had overpaid $298,544.10, on bills submitted under plaintiff's provider number. This figure included 51 overpayments due to failure to produce medical records in the amount of $2,030.42; 2,758 overpayments due to failure to produce documentation of specific services in the amount of $122,800.72; 42 overpayments due to improper procedure code billings in the amount of $884.55; and 2,681 overpayments due to billing for noncovered services in the amount of $172,828.41. This sample was extrapolated to $639,008.99, for the universe.

In November 2002, the Department began an administrative proceeding against plaintiff for recoupment of the overpaid monies and termination of plaintiff's participation as a vendor under the Medicaid program. In January 2003, plaintiff filed a motion to join YES as a necessary party because of YES's involvement in the billing and receipt of the payments to the Department. Plaintiff also asserted that YES was jointly and severally liable for the payments under the alternate payee agreement. The administrative law judge denied plaintiff's motion, finding that YES's joint and several liability was not a sufficient basis to compel the Department to in-plead

YES as a party to the administrative action. Plaintiff filed a motion to reconsider this ruling and later filed a renewed motion to a join necessary party, both were denied by the administrative law judge.

The administrative hearing began in March 2004 and continued over numerous dates until March 2009. In November 2004, plaintiff filed a motion to stay proceedings pending resolution of the criminal prosecution against Jennings for vendor fraud and theft. Plaintiff maintained that if Jennings was convicted and required to make restitution, then the Department would have no further grounds for administrative proceedings against him. The administrative law judge denied the motion.

Over the course of the hearing, the Department presented the testimony of Hope Little, the Department auditor and Dr. John Nosari, a statistical expert. Plaintiff presented the testimony of Jennings and himself.

Little testified regarding the Department's audit and reaudit of plaintiff's records, which she conducted. Little explained her process in examining plaintiff's records and the discrepancies she found. She detailed each of the types of billing discrepancies and the amounts. Her testimony went through the hard dollar amounts for the discrepancies, the total amount under the sample, and the extrapolated amount for the universe. Plaintiff has not disputed Little's findings in the audit or her audit process.

Nosari testified for the Department as an expert in auditing. He explained the central limit theorem, which is the basis of statistical extrapolation. He detailed how a random sample is selected from a total universe. A universe is 100% of a defined population. He stated that in a

"simple random sample," each item has an equal chance of being selected. He testified that the Department used a computer program with a random number generator to randomly select the recipients for the sample. Each Medicaid recipient has a unique identification number which allowed the computer program to generate a random sample. In this case, the random sample was 234 from a universe of 569 recipients.

Under this sample, the extrapolation would provide a 95% confidence level, which is a very high level of confidence. Nosari testified that this yielded a best estimate total for overpayments during the audit period of $725,946, and the figure sought by the Department, $639,008.99, was the lower limit of the 95% confidence level. This meant that there was a 97 ½% probability that the actual overpayments were that amount or higher. Nosari opined that based on his review of the audit process, the audit sample and extrapolation method used were statistically valid and provided a random, representative, and efficient audit sample.

On cross-examination, Nosari admitted that he did not know that plaintiff had provided services at more than one location, but he stated that the random sample would be representative of all plaintiff's billings. When asked if the stratification method would have been more accurate than extrapolation, Nosari responded, "theoretically *** but it may not." Nosari said that in this case the confidence level indicated the accuracy of the audit sample. He said the confidence interval was relatively small, which showed a high level of confidence.

Plaintiff filed a motion to find for the vendor at the conclusion of the Department's case, which was taken with the case.

Jennings, who appeared under subpoena, testified that she was the CEO of YES. She

admitted that she executed the alternate payee agreement with plaintiff. She stated that for part of plaintiff's employment, the billing was handled by another company, Palmer Medical Billing. In 1999, an employee was hired at YES to perform the billing duties. Jennings disputed plaintiff's assertion that he was not responsible for and had no knowledge of bills submitted under his provider number. She testified that she spoke with plaintiff regarding the billing of Medicaid recipients and that YES billed the Department for plaintiff's services under the provider number. She stated that she assumed plaintiff reviewed the bills prepared by YES and submitted to the Department.

Plaintiff testified that he was recruited to work for YES during his residency and detailed his employment relationship with YES. He stated that he had been a Medicaid provider prior to his employment with YES. He admitted to signing the alternate payee agreement for YES to bill the Department under his provider number, but said he did not read every provision carefully. He denied having any responsibility over billing and did not have a supervisory role at YES. He did not review or sign any bills for Medicaid recipients that were submitted to the Department. Both he and Jennings testified that no power of attorney was executed to authorize YES to bill the Department and receive payments on plaintiff's behalf.

On April 28, 2009, the administrative law judge issued her report and recommended decision.[2] The judge concluded that the "undisputed testimony of the auditor confirmed the

[2] During the pendency of the administrative hearing, administrative law judge Michael Bradley was unable to continue on the case and administrative law judge Stacy Cooper was assigned to the case.

allegations set forth in the Statement of Grounds, that [plaintiff] failed to produce patient medical records, failed to produce patient records of specific services, improperly coded billed for procedures and billed for unauthorized services." The judge found that the auditor's testimony established violations of the Illinois Administrative Code and policy provisions concerning record requirements from the Handbook for Physicians. The judge noted that plaintiff

> "did consent to the use of his provider number by YES when he executed the Alternate Payee Agreement. He cannot circumvent his responsibility. [Plaintiff] executed a provider agreement wherein he agreed to be fully liable to the Department for any overpayments resulting from billings to the Department. He executed the Alternate Payee Agreements with sundry providers, he worked at the facilities and he treated recipients of the [Medicaid program]. [Plaintiff's] lack of knowledge does not vitiate his responsibility. His failure to take affirmative steps to ensure the proper use of his provider number and compliance with program policy and rules is at best evidence of poor judgment."

The administrative law judge further

> "determined that [plaintiff] did not actively participate in the billing scam with YES and it is understood from [plaintiff's] testimony that he cooperated in the prosecution of Ms. Jennings' criminal case. However, the ALJ is not convinced that [plaintiff]

> was completely unaware of what was occurring when he worked with YES. Even if [plaintiff] was completely naive and idealistic about his business relationship with YES, he remained a steward of program funds, which carried with it responsibilities and accountability."

The administrative law judge recommended that plaintiff's participation in the Medicaid program be terminated and the Department be repaid $639,008.99. The judge also recommended the denial of plaintiff's motion to find for vendor at the close of the Department's case.

In May 2009, plaintiff filed his exceptions to the recommended decision of the administrative law judge. Plaintiff raised eight exceptions: (1) he should not be held accountable for another's criminal actions; (2) the denial of YES as a party was fatal to the Department's case; (3) the denial of vendor's motion to find for vendor at the close of the Department's case was improper; (4) the alternate payee agreement was invalid because YES was not a hospital, school, group practice or other required entity; (5) the required powers of attorney were not submitted to the Department; (6) extrapolation of the hard dollar findings was not warranted; (7) plaintiff was not a vendor and not subject to section 140.16 of the Illinois Administrative Code (89 Ill. Adm Code 140.16); and (8) termination was not appropriate in this case. The Department filed a response to plaintiff's exceptions.

In June 2009, Barry Maram, as the Department's director, (the Director) issued his finding. He stated that he had reviewed the recommended decision of the administrative law judge, plaintiff's exceptions and the Department's response. Based on his review, he adopted the

recommended decision as his final decision. Accordingly, plaintiff's participation in the Medicaid program was terminated and the Department was entitled to recover $639,008.99.

In July 2009, plaintiff filed a complaint for administrative review in the circuit court. In April 2010, following briefing and oral arguments, the circuit court issued its memorandum opinion and order which affirmed the Department's decision and entering judgment against plaintiff for $639,008.99.

This appeal followed.

We first consider plaintiff's assertion that the Director erred in adopting the recommendations of the administrative law judge that plaintiff's participation in the Medicaid program be terminated and he repay the Department for the billing overpayments.

When a party appeals the circuit court's decision on a complaint for administrative review, the appellate court's role is to review the administrative decision rather than the circuit court's decision. *Siwek v. Retirement Board of the Policemen's Annuity & Benefit Fund*, 324 Ill. App. 3d 820, 824 (2001). The Administrative Review Law provides that judicial review of an administrative agency decision shall extend to all questions of law and fact presented by the entire record before the court. 735 ILCS 5/3-110 (West 2008). Further, "[t]he findings and conclusions of the administrative agency on questions of fact shall be held to be *prima facie* true and correct." 735 ILCS 5/3-110 (West 2008). "The standard of review, 'which determines the degree of deference given to the agency's decision,' turns on whether the issue presented is a question of fact, a question of law, or a mixed question of law and fact." *Comprehensive Community Solutions, Inc. v. Rockford School District No. 205*, 216 Ill. 2d 455, 471 (2005),

(quoting *AFM Messenger Service, Inc. v. Department of Employment Security*, 198 Ill. 2d 380, 390 (2001)).

"A mixed question of law and fact asks the legal effect of a given set of facts." *Comprehensive Community*, 216 Ill. 2d at 472. Stated another way, a mixed question is one in which the historical facts are admitted or established, the rule of law is undisputed, and the issue is whether the facts satisfy the statutory standard, or whether the rule of law as applied to the established facts is or is not violated. *AFM Messenger*, 198 Ill. 2d at 391. Here, the question of whether plaintiff violated the administrative code and should be liable to the Department for billing overpayments presents a mixed question of law and fact. A mixed question of law and fact is reviewed under the clearly erroneous standard. *Comprehensive Community*, 216 Ill. 2d at 472.

The clearly erroneous standard of review lies between the manifest weight of the evidence standard and the *de novo* standard, and as such, it grants some deference to the agency's decision. *AFM Messenger*, 198 Ill. 2d at 392. "When the decision of an administrative agency presents a mixed question of law and fact, the agency decision will be deemed 'clearly erroneous' only where the reviewing court, on the entire record, is 'left with the definite and firm conviction that a mistake has been committed.' " *AFM Messenger*, 198 Ill. 2d at 395 (quoting *United States v. United States Gypsum Co.*, 333 U.S. 364, 395 (1948)). Nonetheless, that the clearly erroneous standard is largely deferential does not mean, however, that a reviewing court must blindly defer to the agency's decision. *AFM Messenger*, 198 Ill. 2d at 395.

Plaintiff raises multiple reasons why the Director erred in finding plaintiff liable to the

Department. First, plaintiff contends that the Director erred in holding him solely liable for Jennings' criminal actions. Plaintiff states it is "unjust" to hold him responsible for Jennings' crimes when he assisted the authorities in Jennings' criminal proceedings. Plaintiff fails to cite any portion of the Illinois Administrative Code or case law to support his assertion.

Moreover, plaintiff has been held liable to the Department for his own failure to comply with the Department's policies, rules and regulations as a provider in the Medicaid program. Under the provider agreement, plaintiff agreed "to be fully liable for the truth, accuracy and completeness of all claims submitted" and "to be fully liable to the Department for any overpayments which may result from the Provider's submittal of billings to the Department." Plaintiff entered into the alternate payee agreement with YES and then failed to ensure that the billings submitted on his behalf were accurate.

In *Lebajo v. Department of Public Aid*, 210 Ill. App. 3d 263 (1990), the plaintiff physician presented a similar argument as plaintiff does in the present case. There, the physician applied to participate in the Medicaid program and later joined a group medical practice. The physician executed a power of attorney permitting an employee of the group practice to submit billings on his behalf to the Department and designated the group practice as an additional payee. The physician resigned from the group practice after two months and he left all patient records with the group practice.

Later, the physician received notice of an audit of his records for the patients he saw while part of the group practice. He informed the auditors that the records remained at the group practice and did not produce them. He later produced 64 records, but despite the issuance of a

subpoena at his request, he failed to produce any additional records. The Department issued an administrative decision that terminated the physician's participation in the Medicaid program and he was ordered to repay $15,118.11, to the Department for overpayments, which the circuit court upheld on administrative review. *Lebajo*, 210 Ill. App. 3d at 265-68.

On appeal, the physician contended that it was the group practice, not the individual practitioner, which was responsible for maintaining and providing the records to the Department. The reviewing court disagreed with the physician.

> "Plaintiff has the legal duty to maintain these records and nothing contained in this Code relieves plaintiff of or modifies this duty. It has been held that this statutory provision gives participants in the Medical Assistance Program, such as plaintiff, notice of their duty to meet minimal professional recordkeeping standards. *Boffa v. Illinois Department of Public Aid*, 168 Ill. App. 3d 139, 144 (1988).
>
> The individual participant is also made aware of this duty in the Handbook for Physicians, which is given to medical dispensers upon acceptance into the Medical Assistance Program. Upon receipt of the Handbook, the individual participant is put on notice that he retains the ultimate responsibility to maintain and provide the [Department] with patient records upon their request. See, *Skale v. Department of Public Aid*, 165 Ill. App. 3d 776 (1987)

> ([Department] decision to terminate medical dispenser upheld for failure to produce records where the records are in the hands of a third party)." *Lebajo*, 210 Ill. App. 3d at 269.

The *Lebajo* court further found that "the ultimate responsibility to provide the [Department] with patient medical and billing records cannot be avoided by the individual participant merely because the [Department] permits restricted assignment of some of the participant's duties." *Lebajo*, 210 Ill. App. 3d at 270. The court specifically noted that this result was especially compelling given the public policy behind the Medicaid program to provide health care services to those who cannot afford such services and the failure to comply with the requirements to maintain and provide records would result in the inability to verify the use of the Department's funds under the program and the potential misuse of taxpayer's money. *Lebajo*, 210 Ill. App. 3d at 270. The court concluded that "the provisions of the Illinois Public Aid Code and the rules and regulations adopted pursuant thereto places upon the individual practitioner the ultimate responsibility to maintain and produce patient records to the [Department]" and it is not a valid defense to claim this responsibility was delegated to a third party. *Lebajo*, 210 Ill. App. 3d at 271.

The physician further argued that it was improper to seek the amount of the overpayment from him because he did not receive the money, the payment was made to the group practice. The reviewing court was not persuaded and found that the physician's ability to assign payment to the group practice did not relieve him of the "ultimate responsibility" to maintain and provide patient records. *Lebajo*, 210 Ill. App. 3d at 271.

In the present case, plaintiff was penalized for his failure to comply with the Department's rules and policies, which he agreed to when he signed the provider agreement. Plaintiff's failure to ensure that YES was properly using his provider number in its billings to the Department was the reason for this action. The actions of a third party, *i.e.*, Jennings, have no bearing on plaintiff's liability to the Department.

Plaintiff next raises several arguments related to the alternate payee agreement and YES. Specifically, he contends that (1) the alternate payee agreement is invalid because YES does not fit within the definition of an "alternate payee," (2) he should not be held liable because a power of attorney executed by plaintiff and YES was not produced and without such a document, YES could not properly submit claims to the Department; (3) YES was a necessary party to this action; and (4) the court should have exercised judicial estoppel to prevent the Department from presenting contrary positions as to the validity of the alternate payee agreement.

Plaintiff points out that the alternate payee agreement indicated on the form that it was for "hospital, professional school or group practice as alternate payee" and contends that YES did not fit within any of these organizations. However, the validity of an alternate payee agreement was not a prerequisite to the Department's effort to recover its overpaid funds.

Section 140.25(a) of the Illinois Administrative Code provides:

> "When the Department, the provider, or the designated alternate payee has determined that an overpayment has been made, the provider or the alternate payee shall reimburse the Department for the overpayment. The Department shall recover

> overpayments made to or on behalf of a provider that result from improper billing practices. Such recovery may occur by setoff, crediting against future billings or requiring direct repayment to the Department." 89 Ill. Adm. Code 140.25(a) (2010).

Further, section 140.15(b) states:

> "If a practitioner designates an alternate payee, the practitioner and the alternate payee shall be jointly and severally liable to the Department for payments made to the alternate payee. Recoveries by the Department may be made against either party or both, at the Department's option." 89 Ill. Adm. Code 140.15(b) (2010).

Both of these sections of the Illinois Administrative Code establish that plaintiff remained responsible to the Department for any overpayments. While plaintiff and YES, as an alternate payee, were jointly and severally liable, the Department was not required to seek repayment from both of them and could opt for repayment from plaintiff alone, which it did here. As we previously stated, plaintiff agreed to be "fully liable" under the provider agreement for the accuracy of claims and to the Department for any overpayments.

Plaintiff's agreement to participate in the Medicaid program was never altered or extinguished by the execution of the alternate payee agreement. Plaintiff entered into an agreement with the Department and no other document changed that responsibility. Whether YES fit within a category listed in the alternate payee agreement is irrelevant to plaintiff's

accountability to the Department. Thus, plaintiff's contention that the alternate payee agreement is invalid because YES did not fit in the definition of an "alternate payee" is unavailing.

Moreover, plaintiff never contested that he entered into this agreement with Jennings, on YES's behalf, and that YES billed the Department for plaintiff's services. It is undisputed that YES billed the Department on plaintiff's behalf and plaintiff agreed to that arrangement. Plaintiff's obligations to the Department existed outside of the alternate payee agreement.

Similarly, we note that the requirement for a power of attorney was contained in the alternate payee agreement to which the Department was not a party. As with the alternate payee agreement, the lack of a power of attorney did not change plaintiff's responsibilities to the Department. Therefore, the validity of the alternate payee agreement and the lack of a power of attorney document were irrelevant to the Department's proceedings against plaintiff.

Plaintiff also asserts that the Director erred in failing to apply the judicial estoppel doctrine. Specifically, plaintiff argues that the Department set forth inconsistent positions that the alternate payee agreement was invalid for purposes of adding YES as a necessary party and valid for holding plaintiff liable for overpayments. The Department maintains that it has not asserted inconsistent litigation positions.

The judicial estoppel doctrine applies when: "the party to be estopped must have (1) taken two positions, (2) that are factually inconsistent, (3) in separate judicial or quasi-judicial administrative proceedings, (4) intending for the trier of fact to accept the truth of the facts alleged, and (5) have succeeded in the first proceeding and received some benefit from it." *People v. Caballero*, 206 Ill. 2d 65, 80 (2002). The application of the judicial estoppel doctrine

is within the discretion of the court. *Caballero*, 206 Ill. 2d at 80.

Here, plaintiff contends that it is "undisputed" that the Department took inconsistent positions during the administrative proceedings. First, the Department asserted that the alternate payee agreement was invalid for purposes of joining YES as a necessary party, and then, the Department argued that the agreement was valid for purposes of imposing liability against plaintiff.

However, when plaintiff raised this issue in the administrative hearing, the administrative law judge declined to apply the judicial estoppel doctrine, finding that the Department "did not argue that the Alternate Payee Agreement was valid for any purpose in this litigation. No contrary position having been argued, the judicial estoppel elements are not met."

The Department admits that it argued that YES may not have been a proper alternate payee under the agreement and that it may not have been authorized to pursue YES in the administrative proceeding, but maintains that it never asserted that the agreements did not impose any legal duties on either plaintiff or YES. Rather, the Department's position was that plaintiff was individually liable to the Department based on the provider agreement and the regulations. Plaintiff's liability existed regardless of YES's role.

We reach the same conclusion as the administrative law judge. The Department has not presented inconsistent positions on the alternate payee agreement. The Department has consistently asserted that plaintiff was liable for the overpayments based on the provider agreement and the Handbook for Physicians, which plaintiff received. The Department did not contend that plaintiff's liability was contingent on the validity of the alternate payee agreement.

Accordingly, the administrative law judge did not abuse her discretion when she declined to apply the judicial estoppel doctrine.

Plaintiff further argues that YES was a necessary party to the administrative action pursuant to section 104.241 of the Illinois Administrative Code and the Director and the administrative law judge erred in denying his motions to join YES to the administrative proceedings. Plaintiff also contends that the failure to join YES in the administrative proceedings violated his due process rights. The Department responds that plaintiff was individually liable to the Department. Further, the Department points out that plaintiff was permitted to present evidence regarding YES's role in the billings to the Department and argued this as his defense. The Department notes that plaintiff could have filed an action against YES in the circuit court for his liability to the Department.

"A party is necessary where its presence in a lawsuit is required in order to: (1) protect an interest which the absentee has in the subject matter which would be materially affected by a judgment entered in his absence; (2) reach a decision which will protect the interests of those who are before the court; or (3) enable the court to make a complete determination of the controversy." *State Farm Fire & Casualty Co. v. John J. Rickhoff Sheet Metal Co.*, 394 Ill. App. 3d 548, 563 (2009).

Section 104.241 provides:

> "At any time before completion of the hearing, amendments may be allowed on just and reasonable terms to introduce any party who ought to have been joined, to dismiss any party, or to delete,

modify or add allegations or defenses." 89 Ill. Adm. Code 104.241 (2010).

However, as we have previously noted section 140.15(b), which sets forth that a practitioner and alternate payee will be jointly and severally liable, allows the Department to seek recovery "against either party or both, at the Department's option." 89 Ill. Adm. Code 140.15(b) (2010). The Department exercised its recovery option in this case when it sought repayment from plaintiff alone, as it was within its right to do. As we have already found, plaintiff's liability to the Department exists regardless of YES's role in the overpayments made by the Department. Likewise, plaintiff's ability to seek recovery from YES is not tied to the Department's right to seek recovery from plaintiff. See *Lebajo*, 210 Ill. App. 3d at 271 (physician found liable regardless of the fact that the group practice was responsible for billing and received the funds from the Department).

YES was not a necessary party to this action because its absence did not affect the Department's ability to recover the overpayments nor did it change plaintiff's liability to the Department under the provider agreement. Further, the administrative proceedings against plaintiff were able to be fully resolved without YES's joinder.

Further, plaintiff was not deprived of his due process rights with the decision to deny joinder of YES. Due process applies to both courts and administrative agencies that perform adjudicatory functions, but the requirements of due process in judicial proceedings differ from those in administrative proceedings. *SMRJ, Inc. v. Russell*, 378 Ill. App. 3d 563, 570 (2007). Administrative proceedings are less formal and due process requirements are satisfied by a " ' "

procedure that is suitable and proper to the nature of the determination to be made and conforms to fundamental principles of justice." ' " *SMRJ*, 378 Ill. App. 3d at 570 (quoting *Comito v. Police Board*, 317 Ill. App. 3d 677, 687 (2000), quoting *Telcser v. Holzman*, 31 Ill. 2d 332, 339 (1964)). In an administrative proceeding, the "procedure must include the opportunity to be heard, the right to cross-examine adverse witnesses, and impartial rulings on the evidence." *SMRJ*, 378 Ill. App. 3d at 570-71.

Due process requirements were satisfied in this case. Plaintiff was given ample chances to present witnesses in his case, cross-examine the Department's witnesses, and obtain rulings by an impartial administrative law judge. Specifically, plaintiff was able to testify and present evidence about Jennings' conduct on behalf of YES and to cross-examine the Department's witnesses about the audit procedure. Plaintiff was given a full opportunity to mount a defense to the Department's allegations. Plaintiff asserted that he was unaware of the billing scheme perpetuated by YES and Jennings and he did not receive the excess funds. The administrative law judge noted in her findings that she determined that plaintiff did not actively participate in the billing scam, but found that plaintiff's role as a provider in the Medicaid program made him "a steward of program funds, which carried with it responsibilities and accountability."

The Department had the option to seek recovery from both plaintiff and YES, but chose to seek repayment from plaintiff alone. YES was not a necessary party to the Department's claims against plaintiff. Accordingly, we find that the Director's decision was not clearly erroneous.

Next, plaintiff contends that the Director erred in finding that the extrapolation method

used by the Department was statistically valid. The Department maintains that its use of the statistical extrapolation method of the audit sample to calculate the overpayments was statistically valid.

Section 140.30(b) of the Illinois Administrative Code provides:

> "(b) The Department's procedure for auditing providers may involve the use of sampling and extrapolation. Under such a procedure, the Department selects a statistically valid sample of the cases for which the provider or designated alternate payee received payment for the audit period in question and audits the provider's records for those cases. All incorrect payments determined by an audit of the cases in the sample are then totaled and extrapolated to the entire universe of cases for which the provider or designated alternate payee has been paid during the audit period. The provider or designated alternate payee shall be required to pay the Department the entire extrapolated amount of incorrect payments calculated under this procedure after notice and opportunity for hearing pursuant to 89 Ill. Adm. Code 104.210." 89 Ill. Adm. Code 140.30(b) (2010).

Defendant relies on the Fifth District's decision in *Protestant Memorial Medical Center, Inc. v. The Department of Public Aid*, 295 Ill. App. 3d 249 (1998). Similar to the facts present in the instant case, in *Protestant Memorial*, the hospital sought administrative review after the

Department of Public Aid sought money it had overpaid under the Medicaid program. Nosari testified at the administrative hearing about the use of the extrapolation method to determine the amount of overpayment based on a sample. *Protestant Memorial*, 295 Ill. App. 3d at 251-52.

The hospital presented its own expert in statistics, Dr. Ik-Whan Kwon, to testify at the hearing. Kwon testified that the Department should have used "stratified services, *i.e.*, grouping services into the three categories of institutional, general medical, and pharmacy, as the unit of analysis for the universe and the sample, rather than recipient." *Protestant Memorial*, 295 Ill. App. 3d at 252. Kwon stated that

> "simple random sampling, which was used here, is an acceptable statistical method, but it is appropriate only when the unit of analysis is homogeneous, *i.e.*, when each recipient received a similar amount of either services or payments. If the unit of analysis is not homogeneous, then simple random sampling of the recipients results in grossly exaggerated variations and the randomness creates a biased result. Additionally, Kwon stated that a computerized random sample does not guarantee randomness, as randomness is determined by whether a sample is selected in the fashion that the population is distributed." *Protestant Memorial*, 295 Ill. App. 3d at 252.

Kwon also found that the sample used in this case was not proportionate to the universe and "concluded that if a sample is not random, efficient, and representative of the universe, or if

any of these three criteria are violated, then a sample is invalid and extrapolation is useless." *Protestant Memorial*, 295 Ill. App. 3d at 253.

In response, the Department presented another expert, Dr. Donald Roberts. Roberts testified that the Department "applied valid statistical principles to the audit, *i.e.*, the Department followed all of the proper steps" and disagreed with Kwon's conclusion that the sample was invalid. Roberts agreed with Kwon about the criteria for efficient testing, but found that just because one method was more efficient, it did not render another method invalid. *Protestant Memorial*, 295 Ill. App. 3d at 253.

The administrative law judge found the Department used a statistically valid sample in its audit. On review, the trial court reversed and found that the Department did not use a valid sample and extrapolation and reduced the award to the actual amount of the discrepancy from the audit. *Protestant Memorial*, 295 Ill. App. 3d at 253-4.

On appeal, the reviewing court considered what constituted a "statistically valid sample" under the Department's rules and regulations and concluded that the only interpretation of that phrase came from the expert testimony. The court found:

> "Kwon's definition provides the most comprehensive, most just, and fairest legal interpretation of the phrase "statistically valid sample." If a sample is not representative, efficient, and random, then it would seem that any sample would meet the Department's rules, as long as the methods applied to that sample are statistically sound. It is a reasonable inference that if the basic underlying

> selection of a sample does not meet the three criteria set forth by Kwon, then no matter how sound the statistical methods applied are, the result would be useless and invalid upon extrapolation. It appears that the trial court accepted Kwon's interpretation."
>
> *Protestant Memorial*, 295 Ill. App. 3d at 255-56.

Here, unlike the hospital in *Protestant Memorial*, plaintiff failed to present any expert testimony to contradict Nosari's testimony that the sample was representative, efficient and random, and the extrapolation method was statistically valid with a confidence level of 95%. Instead, plaintiff's argument hinges on Nosari's responses to a few questions about plaintiff's work at multiple locations and he contends that Nosari "conceded that stratification would have been a more accurate method of extrapolation." However, plaintiff has not explained how this knowledge made the sample invalid. Though plaintiff asserts that some claims had no chance of being selected for the sample, plaintiff has not provided any citation to the record to support his assertion. The sample was taken from a universe of all the recipients billed to the Department from plaintiff's provider number.

Moreover, Nosari was specifically asked if stratification of the units created a more accurate extrapolation and he responded, "theoretically *** but it may not." Contrary to plaintiff's assertion, Nosari testified that the sample was efficient, random and representative of the universe of the recipients billed under plaintiff's provider number. Plaintiff has failed to present any evidence to challenge the audit findings and Nosari's expert testimony. Therefore, we affirm the Director's finding that the Department's extrapolation was statistically valid.

Finally, plaintiff argues that the Director erred in terminating his participation in the Medicaid program. Specifically, plaintiff asserts that section 140.16 of the Illinois Administrative Code permits the termination or suspension of a "vendor's eligibility to participate" in the Medicaid program (89 Ill. Adm. Code 140.16 (2010)), but he does not meet the definition of a "vendor" and cannot be terminated under this section. Alternatively, plaintiff contends that even if he was a vendor, then the appropriate sanction should have been suspension from the Medicaid program, not termination. The Department maintains that the Director had the authority to terminate plaintiff's participation in the Medicaid program.

Section 12-4.25 of the Illinois Public Aid Code permits the Department to deny, suspend or terminate the eligibility of any person to participate as a vendor under the Medicaid program based on a failure to comply with the Department's policy, rules or regulations; or for a failure to keep or make available for inspection any records for payments claimed for services under the Medicaid program; or for a failure to furnish information requested by the Department regarding payments for providing services. See 305 ILCS 5/12-4.45(A)(a), (A)(b), (A)(c) (West 2002).

In November 2002, at the time this action was initiated, the Illinois Administrative Code defined "vendor" as "a person, firm, corporation, association, agency, institution, or other legal entity receiving payment or applying for authorization to receive payment for goods or services to a recipient or recipients." 89 Ill. Adm. Code 140.13 (2010). Plaintiff asserts that he does not meet this definition because he did not receive payments from the Department nor did he apply to receive payment. Instead, he contends that YES was the only entity that applied for and received payments from the Department. However, plaintiff admitted in his answer to the Department's

statement of grounds that he was a vendor.

> "1. That the Respondent, as a provider of medical services, is a vendor participating in the Illinois Medical Assistance Program administered by the Department and did participate as an eligible [*sic.*] in the Illinois Medical Assistance Program during the period December 1, 1998 through November 30, 2000.
>
> **ANSWER:**
>
> Fernando admits Paragraph 1."

Nevertheless, even if plaintiff had not admitted in a pleading that he was a vendor, plaintiff did satisfy the definition of a "vendor" because he applied to receive funds from the Department as a provider under the Medicaid program. He enrolled in the Medicaid program to provide services to recipients and to receive payment for billings from the Department. Plaintiff's authorization of YES as an entity to bill the Department on plaintiff's behalf does not negate his role as a vendor for the Department. Even with YES as an alternate payee, plaintiff received payment for his services to Medicaid recipients. Accordingly, plaintiff satisfied the definition of "vendor" under the Illinois Administrative Code.

Plaintiff also contends that a suspension was a more appropriate sanction than termination because YES was the entity responsible for billing the Department and he did not participate in the overbilling. He also points out that he had no additional history with the Department.

"When considering an administrative sanction, a reviewing court " 'defers to the

administrative agency's expertise and experience in determining what sanction is appropriate to protect the public interest.' " *Gruwell v. Illinois Dept. of Financial and Professional Regulation*, 406 Ill. App. 3d 283, 295 (2010) (quoting *Abrahamson v. Illinois Department of Professional Regulation*, 153 Ill. 2d 76, 99 (1992)). The agency's sanction will be reversed only if it is arbitrary or capricious or was an abuse of discretion. *Gruwell*, 406 Ill. App. 3d at 295.

The administrative law judge found that plaintiff carried responsibilities and was accountable to the Department for the payments. The judge noted that she was "not convinced that [plaintiff] was completely unaware of what was occurring when he worked with YES." The auditors found 6,000 discrepancies, totaling $639,008.99. Plaintiff's decision to delegate billing to YES did not excuse his responsibilities under the provider agreement and handbooks to maintain documentation for claimed services. Given the severity of the overpayments made by the Department, we cannot say that the Director's decision to terminate plaintiff from the Medicaid program was in error.

Based on the foregoing reasons, we affirm both the findings of the Director and the decision of the circuit court of Cook County.

Affirmed.