ISSUE

Whether the Department properly issued an Order of Summary Suspension to Petitioner on March 11, 2021?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Since REDACTED 1984, Petitioner has been an enrolled provider in in the Michigan Medicaid Program. (Exhibit A, page 489-494).

2. His specialties include addiction and pain management. (Testimony of Petitioner; Testimony of Internal Auditor).

3. On August 2, 2013, an administrative complaint was filed with the Disciplinary Subcommittee of the Board of Medicine of the Bureau of Health Care Services of the Department of Licensing and Regulatory Affairs (LARA) for the State of Michigan with respect to Petitioner. (Exhibit A, pages 256-272).

4. The complaint related to Petitioner's conduct in prescribing methadone, a schedule 2 narcotic, for multiple patients. (Exhibit A, pages 256-272).

5. On July 16, 2014, Petitioner and the Disciplinary Subcommittee entered into a Consent Order and Stipulation in which they agreed that the Disciplinary Subcommittee could treat the allegations of fact and law in the complaint as true; the Disciplinary Subcommittee would dismiss two of the counts against Petitioner; the Disciplinary Subcommittee would find that Petitioner's conduct constituted negligence in violation of MCL 333.16221(a); and Petitioner would pay a fine of $2,000.00 with respect to that violation. (Exhibit A, pages 273-276, 286).

6. On January 19, 2018, the Department's Office of Inspector General (OIG) sent a Complaint Referral to the Health Professions Division of the Bureau of Health Care Services of LARA with respect to Petitioner's prescribing habits with respect to the medication Gabapentin. (Exhibit A, pages 20-21).

7. LARA then initiated an investigation. (Exhibit A, pages 279-280).

8. On May 24, 2019, an administrative complaint was filed with the Disciplinary Subcommittee of the Board of Medicine of the Bureau of Health Care Services of LARA with respect to Petitioner prescribing practices with respect to the medication Gabapentin, a drug known to be used and diverted. (Exhibit A, pages 277-285, 287-295).

9. On February 19, 2020, Petitioner and the Disciplinary Subcommittee

entered into a Consent Order and Stipulation in which they agreed that the Disciplinary Subcommittee could treat the allegations of fact and law in the complaint as true; the Disciplinary Subcommittee would find that Petitioner's conduct constituted negligence and a departure from minimal standards of practice in violation of MCL 333.16221(a) and (b)(i); and that Petitioner would be placed on probation for one year. (Exhibit A, pages 495-500).

10. No limitations were placed on Petitioner's ability to practice or prescribe medications. (Exhibit A, pages 495-500; Testimony of Petitioner).

11. Petitioner is a participating provider with Upper Peninsula Health Plan (UPHP), a Medicaid Health Plan (MHP) contracted with the Department. (Testimony of Petitioner; Testimony of Internal Auditor; Testimony of Section Manager).

12. In January of 2020, a Benefits Monitoring Program (BMP)[1] Case Manager at UPHP reported to both UPHP and Respondent's BMP contact at the Department her concerns that, for multiple years and for multiple beneficiaries, Petitioner was prescribing drugs that require prior authorization, but then is refusing to request prior authorization, so the beneficiaries were required to pay out of pocket. (Exhibit A, pages 244-245).

13. In February of 2020, the UPHP Medical Director received a telephone call from a doctor who expressed concerns about Petitioner's prescribing habits with respect to controlled substances, including the amount and dosing. (Exhibit A, page 24).

14. In a letter to UPHP's Medical Director dated March 19, 2020, a Dr. Amy Fletemier wrote in part:

> I am writing this letter out of concern for the UPHP BMP patients for which I have agreed to provide primary care. As you know, the goal for these patients is to keep them as well as possible without them suffering harm from the medical system due to their utilization of it.
>
> Unfortunately, this goal is not fully achievable with my two current BMP patients because they are seeing Dr REDACTED REDACTED. Though I fully support medical assisted treatment (MAT) for opiate use disorders, he is not providing this treatment within

[1] "The Benefits Monitoring Program (BMP) is in place to closely monitor program usage and to identify members who may be potentially over utilizing or misusing their UPHP services and benefits." (Exhibit A, page 28).

current standards of care. Specifically:

1. He prescribed multiple, high dose scheduled substances in addition to the patient's MAT. Both of my patients are on very high doses of methylphenidate and gabapentin, in addition to the Suboxone they are taking. His methylphenidate dosing is well in excess of standard treatment dosing for ADD, with all of his scripts being rapid acting QID schedules. Benzodiazepines are absolutely contradicted when using an opioid medication due the high risk of accidental overdose. Yet, both patients receive benzodiazepines from Dr. REDACTED.

2. Unwillingness to coordinate care appropriately. When using controlled substances, only one physician should be prescribing the controlled substances. One of my patients is receiving MAT from a local freestanding clinic, and Dr. REDACTED is also seeing her and giving her other controlled substances. The other patient is seeing a neurologist for possible seizures, but received her antiseizure medication refills from Dr REDACTED. He also provided her with Wellbutrin, which is contraindicated in seizure disorders and used previously by the patient for skin popping.

My understanding is that as a BMP provider I have no way of restricting my patients from accessing Dr REDACTED's unsafe prescribing habits. Hence, I am bringing the matter to your attention. Undoubtably, his pattern of prescribing is also increasing the amount of pills available on the streets of our community.

Exhibit A, page 233

15. Petitioner's case was then assigned to UPHP's Special Investigative Unit. (Testimony of Internal Auditor).

16. The Special Investigative Unit then reviewed some patient records. (Testimony of Internal Auditor).

17. It did not speak to Petitioner or any complaining physician. (Testimony of Internal Auditor).

18. It also did not determine if any allegations with respect to Petitioner were

accurate or credible. (Testimony of Internal Auditor).

19. On May 11, 2020, UPHP submitted a fraud referral to the Department's OIG with respect to Petitioner. (Exhibit A, pages 10, 24-27).

20. With respect to the "Suspected Fraud Referral Details", the fraud referral submitted by UPHP stated:

> The UPHP Special Investigations Unit (SIU) has received several concerns regarding Dr. REDACTED REDACTED's prescribing habits during Q 1 2020. On 02/10/2020 the UPHP Medical Director, Michael Mlsna, M.D. reported he received a phone call from Dr. Michael Grossman. Dr. Grossman called to express his concerns about Dr. REDACTED REDACTED's prescribing habits of controlled substances. Specifically, the amount and dosing of Subutex, Suboxone, Ritalin and Neurontin. Dr. Grossman is an in-network family practice physician who is employed at Great Lakes Recovery Centers and provides Medication Assisted Treatment (MAT) services. No specific UPHP members were mentioned.
>
> The UPHP SIU received several tips/complaints from our Benefits Monitoring Program (BMP) Care Manager, Patty Cornish, regarding UPHP members enrolled in the BMP who are receiving prescriptions from Dr. REDACTED and their assigned BMP primary care provider (PCP) is concerned with Dr. REDACTED's prescribing habits and lack of care coordination especially since they work for the same health system.
>
> Dr. Amy Fletemier is the assigned BMP PCP for UPHP BMP members: [TM and LP]. Dr. Fletemier reported the following concerns to UPHP:
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> - Allowing patients he treats and prescribes receive MAT at freestanding clinics while he continues to prescribe multiple high dose scheduled substances.
> - Methylphenidate dosing in excess of standard treatment for ADD
> - Prescribing benzodiazepines when it is contraindicated
> - Unwillingness to coordinate care with other physicians that are treating the member

Dr. Fletemier will not approve Dr. REDACTED to prescribe medications for her BMP members. See Attachment 3 regarding Dr. Fletemier's concerns.

When UPHP reviewed the medications being filled for member [TM]. UPHP found member filled the following medications from Dr. REDACTED except for the Suboxone:

- Mirtazapine
- Ambien
- Suboxone: Prescribed by Brandon Whitscell
- Gabapentin
- Lyrica
- Clonazepam
- Methylphenidate

In addition, UPHP discovered Dr. REDACTED was not completing prior authorizations UPHP members for Methylphenidate. The UPHP BMP Care Manager identified that BMP member [SK] was paying cash for her Methylphenidate 20 mg QID because Dr. REDACTED was not completing prior authorizations. Per discussions with Torey Schlaufman at MDHHS-Program Review Division, this dose requires a prior authorization as Medicaid's max dose for this drug is 20mg TID. Torey notified Mike Wenner of this situation on January 17, 2020 who referred it to the Integrity Division on 01/20/2020. Also of note, [SK's] assigned BMP PCP Dr. Thomas Kates also will not approve Dr. REDACTED to prescribe medications for this member. The UPHP BMP Care Manager also identified this similar issue on BMP member [LP] Medicaid ID # 0044789035 with her Methylphenidate prescription.

Exhibit A, pages 24-25

21. Moreover, with respect to the "Factual Explanation of suspected fraud/abuse, the referral stated:

> Dr. REDACTED refuses to obtain authorizations for medications when they are required, which forces members to pay out of pocket for their medications. There are concerns from providers he is ordering higher doses of medication in excess of standard treatment (i.e., Methylphenidate) and the combination of medications he is prescribing is unsafe.

Exhibit A, page 25

22. The Fraud Referral also noted that Petitioner was previously audited by MDHHS in 2014 because of similar concerns and that the approximate range of dollars involved was $88,018.73. (Exhibit A, page 26).

23. In response to the Fraud Referral, the OIG determined that Petitioner was an enrolled Medicaid provider. (Testimony of Section Manager).

24. It also reviewed the contents of the referral and the complaints about Petitioner made by outside physicians and the BMP Case Manager. (Testimony of Section Manager).

25. The OIG did not contact the physicians or the case manager. (Testimony of Section Manager).

26. Nor did it contact Petitioner. (Testimony of Petitioner; Testimony of Section Manager).

27. The OIG did review the past administrative complaints and actions involving Petitioner and LARA. (Testimony of Section Manager).

28. The OIG also pulled a summary of claims involving Petitioner, but it did not analyze them. (Testimony of Section Manager).

29. On May 11, 2020 and June 4, 2020, the OIG forwarded a copy of the Fraud Referral to the Michigan Department of Attorney General Health Care Fraud Division (HCFD). (Exhibit A, pages 10-11).

30. On January 14, 2021, the OIG emailed the HCFD and asked it to respond within 30 days whether the HCFD "accepts, declines, or submits this referral back to UPHP for further development." (Exhibit A, pages 10-11).

31. The OIG also asked that, if the referral was accepted, the HCFD should indicate "whether the Health Care Fraud Division requests a payment

suspension not be imposed, pursuant to 42 CFR 455.23(e)(1)." (Exhibit A, page 10).

32. On March 3, 2021, the HCFD notified the Department's OIG that HCFD had accepted the referral and that Petitioner was under investigation, and that: "Payment suspension in whole or part will not compromise or jeopardize the HCFD investigation." (Exhibit A, page 9; Testimony of Section Manager).

33. On March 11, 2021, the Department issued an Order of Summary Suspension with respect to Petitioner. (Exhibit A. pages 6-8).

34. In part, that Order of Summary Suspension stated:

> The Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) has determined that emergency action is necessary to protect the State's interest in medically indigent individuals and the public funds of the medical assistance program under MCL 400.111f.
>
> MDHHS OIG has determined that evidence exists in support of the summary suspension of REDACTED REDACTED (REDACTED), NPI REDACTED and such evidence includes but is not limited to:
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> 1. It is suspected that REDACTED is over-prescribing controlled substances such as Subutex, Suboxone, Ritalin, and Neurontin to Medicaid beneficiaries.
>
>   a. Medical records indicate REDACTED prescribed high doses of scheduled substances to patients who are also receiving medication-assisted treatment (MAT) services at freestanding clinics. MAT is the use of medications in combination with counseling and behavioral therapies to treat opioid use disorders (OUD).
>
>   b. REDACTED has required patients to pay out of pocket for covered medication that requires prior authorization due to his refusal to obtain prior authorization, including methylphenidate (Ritalin). Methylphenidate is classified as a Schedule II controlled substance, the designation used for

substances that have a recognized medical value but present a high potential for abuse.

c. REDACTED's prescribing habits include methylphenidate dosing in excess of standard treatment for attention-deficit hyperactivity disorder (ADHD) and prescribing benzodiazepines when it is contraindicated, meaning there are conditions or circumstances that indicate that benzodiazepines should not be prescribed. ADHD is a neurological disorder that causes a range of behavior problems such as difficulty attending to instruction, following instructions, completing tasks and social interaction.

2. As a result, REDACTED is suspected to have caused approximately $88,000 to be paid for medications that he prescribed outside of professionally accepted standards.

REDACTED signed a Medical Assistance Provider Enrollment & Trading Partner Agreement on September17, 2008. By signing that agreement, REDACTED agreed to comply with the provisions of 42 CFR §455.104, 42 CFR §455.105, 42 CFR §431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation in the medical assistance program is allowed.

Pursuant to 42 CFR §455.23, MDHHS must suspend all Medicaid payments to a provider after the department determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

Pursuant to Sections 111d, 111e and 111f of the Social Welfare Act, 1939 PA 280; MCL 400.01 et seq., participation as a provider in the Medicaid program is subject to suspension when:

- A reasonable belief that the provider has violated the Medicaid false claims act, Act No. 72 of the Public Acts of 1977, being sections 400.601 to 400.613 of the Michigan Compiled Laws, the health care false claims act, Act No. 323 of the Public Acts of 1984, being sections 752.1001 to 752.1011 of the Michigan Compiled Laws, or a substantially similar statue of another state or the federal government.

- The suspension is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program.

Pursuant to Section 111f of the Social Welfare Act, MDHHS finds that emergency action is required to protect the public funds of the Medicaid program; now therefore,

IT IS HEREBY ORDERED that REDACTED is summarily suspended from any direct or indirect participation in the Michigan Medicaid program commencing on March 15, 2021.

Exhibit A, pages 6-7

35. On March 22, 2021, MOAHR received the request for hearing filed by Petitioner in this matter with respect to the Order of Summary Suspension.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

All Medicaid providers are required to enter into Medicaid Provider agreements:

> (4) A provider shall enter into an agreement of enrollment specified by the director.
>
> *MCL 400. 111b(4)*

The Social Welfare Act, MCL 400.1 *et seq*., provides that as a condition of participation in the Medicaid program a provider must meet all the requirements listed in MCL 400.111b:

> (1) As a condition of participation, a provider shall meet all of the requirements specified in this section except as provided in subsections (25), (26), and (27).
>
> *MCL 400.111b(1)*

A Medicaid provider must also comply with all Department policies and procedures related to the conditions of participation in the Medicaid program, requirements for Medicaid providers, and with all applicable federal laws and regulations. In particular, the Social Welfare Act plainly states:

> (18) A provider shall comply with all requirements established under section 111a (1), (2), and (3).
>
> *MCL 400.111b(18)*

With respect to orders of summary suspension like the one at issue in this case, the Social Welfare Act, specifically MCL 400.111f, provides in pertinent part:

> (1) The director may issue an order incorporating a finding that emergency action is required to protect the state's interest, as the state's interest is described in this subsection by the statement of circumstances warranting emergency action, in any of the following: the public health, welfare, or safety; medically indigent individuals; or public funds of the program of medical assistance. Circumstances that warrant emergency action include, but are not limited to, any of the following:
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> * * *
>
> (b) A reasonable belief that the provider has violated the Medicaid false claims act, Act No. 72 of the Public Acts of 1977, being sections 400.601 to 400.613 of the Michigan Compiled Laws, the health care false claims act, Act No. 323 of the Public Acts of 1984, being sections 752.1001 to 752.1011 of the Michigan Compiled Laws, or a substantially similar statute of another state or the federal government.
>
> * * *
>
> (5) Upon a determination that circumstances described in subsection (1) exist, the director may issue an order for the summary suspension of payments on pending or subsequent claims, in whole or in part, or for the summary suspension of a provider from participation in the program of medical assistance. The summary suspension shall be effective on the

> date specified in the order or on service of a certified copy of the order on the provider, whichever occurs later, and shall remain in effect during administrative or judicial proceedings on the suspension. Upon request of a provider, a contested case hearing pursuant to chapter 4 and chapter 6 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws, shall be commenced not later than 15 days after the summary suspension. If a contested case hearing is requested by a provider relative to an emergency suspension under this section, a hearing shall be held to determine whether the emergency suspension is supported by competent, material, and substantial evidence on the whole record. Under appropriate circumstances, the state department may hold or institute a hearing under section 111c(1), or take an action under section 111d at the same time an action is taken under this section, while an action under this section is pending, or after a decision on an action is made. The presiding officer may consolidate the 2 hearings into a single proceeding in the interest of economy. However, the director shall not make a final decision in a contested case under section 111c(1) or 111d arising from or related to an emergency action or the circumstances upon which an emergency action was taken.
> MCL 400.111f

Moreover, with respect to suspension of payments in cases of fraud, 42 CFR 455.23 states in part:

> (a) Basis for suspension.
>
> (1) The State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.
>
> (2) The State Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments.
>
> (3) A provider may request, and must be granted, administrative review where State law so requires.
>
> * * *

(c) Duration of suspension.

(1) All suspension of payment actions under this section will be temporary and will not continue after either of the following:

(i) The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

(ii) Legal proceedings related to the provider's alleged fraud are completed.

(2) A State must document in writing the termination of a suspension including, where applicable and appropriate, any appeal rights available to a provider.

* * *

(e) Good cause not to suspend payments. A State may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

(1) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

(2) Other available remedies implemented by the State more effectively or quickly protect Medicaid funds.

(3) The State determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.

(4) beneficiary access to items or services would be jeopardized by a payment suspension because of either of the following:

(i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.

(ii) The individual or entity serves a large number of beneficiaries within a HRSA-designated medically underserved area.

(5) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.

(6) The State determines that payment suspension is not in the best interests of the Medicaid program.

(f) Good cause to suspend payment only in part. A State may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

(1) beneficiary access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:

(i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.

(ii) The individual or entity serves a large number of beneficiaries within a HRSA-designated medically underserved area.

(2) The State determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.

(3)

(i) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and

(ii) The State determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

(4) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.

(5) The State determines that payment suspension only in part is in the best interests of the Medicaid program.

A credible allegation of fraud is defined under 42 CFR 455.2 as:

> A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:
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> (1) Fraud hotline tips verified by further evidence.
>
> (2) Claims data mining.
>
> (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Fraud is defined under 42 CFR 455.2 as:

> *Fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Additionally, the Medicaid Provider Manual (MPM) also states in part:

> **6.3 SUSPENSION**
>
> Summary suspension prevents further payment after a specified date, regardless of the date of service (DOS).
>
> If an indication of fraud or Medicaid misuse/abuse is discovered during any of the following, MDHHS considers it as a basis for summary suspension:
>
> - An evaluation of billing practices.
> - The prior authorization (PA) process.
> - An on-site review of financial and medical records and a written report of this review is filed.
> - The construction of a profile to evaluate patterns of utilization of Medicaid beneficiaries served by the provider.
> - A peer review of services or practices.
> - A hearing or conference between MDHHS and the provider (and counsel, if so requested).
> - Indictment or bindover on charges under the Medicaid or Health Care False Claims Act or similar state/federal statute.
>
> *MPM, January 1, 2021 version*
> *General Information for Providers Chapter*
> *Page 18*

Accordingly, in order to support a summary suspension in this case, the Department must show by competent, material and substantial evidence on the record that there is a credible allegation of fraud under 42 CFR 455.23; a reasonable belief that Petitioners violated the Medicaid False Claims Act, the Health Care False Claims Act, or a substantially similar statute of another state or the federal government; or an indication of fraud or Medicaid misuse/abuse under MPM Section 6.3.

In support of the Department's action, the UPHP's Internal Auditor testified that she was assigned to investigate Petitioner's case in the first quarter of 2020 after UPHP's Medical Director received a complaint over the phone from a Dr. Grossman and a letter from a Dr. Fletemier regarding Petitioner's practice of medicine and prescribing habits. She also noted that a BMP staff member at UPHP was also reporting concerns about Petitioner.

The Internal Audit testified that she then confirmed that Petitioner does practice within UPHP's network and documented the concerns raised by the physicians and the BMP staff member, in addition to a report that a third outside physician, a Dr. Kates, will not approve Petitioner to prescribe medications a BMP patient.

She also testified that she is not a medical professional; she did not determine if any allegations of fraud are credible; and that she relied solely on what the physicians and staff member reported, without consulting any experts. She further testified that she did not review any patient records and that there are no member complaints from the two patients specifically identified by Dr. Fletemier. The Internal Auditor also testified that she did not attempt to speak with Petitioner.

She did send the referral on to the Department's OIG, and she went through the form she submitted and the specific allegations contained therein. She also testified that all UPHP members have been reassigned from Petitioner.

The Section Manager for the Department's OIG testified that her section received the fraud referral and documents sent from UPHP and that she then confirmed that he was an enrolled Medicaid provider, with specialties in family medicine and addiction.

She also testified that she then reviewed the allegations found in the fraud referral. She did not conduct an independent investigation into them; reach out to the providers or BMP manager for direct reports or to review for personal animus; obtain any medical records; or attempt to interview Petitioner. The Section Manager did pull a summary of claims related to Petitioner's practice, which totaled over $2 million, but she did not analyze them or have them analyzed. She also reviewed the two earlier LARA administrative actions involving Petitioner.

The Section Manager further testified that the investigation of fraud in this case was mostly left to the HCFD in Attorney General's office and that she referred the case to them, with the HCFD accepting the referral, finding it warranted, and initiating an investigation.

She also testified that the Department has no discretion in suspending providers in cases where there is a credible fraud allegation and that she found such an allegation in this case where Petitioner was alleged to be overprescribing controlled substances and requiring patients to pay out-of-pocket by refusing to obtain the required prior authorizations. In support of that finding, she testified that three outside physicians had raised concerns about Petitioner's prescribing patterns; a UPHP staff member was raising similar concerns based on patient reports; Petitioner had been the subject of earlier administrative actions due to his prescribing habits; and the HCFD had found that an investigation was warranted. She did agree that the language used in order of summary suspension itself was pulled directly from the fraud referral.

In response, Petitioner testified regarding his education and professional background. He also noted that the previous actions by LARA did not result in any limitations in his practice.

With respect to this case, Petitioner testified that the OIG never contacted him or asked him for information and that the summary suspension was a surprise. He was also surprised by the individuals making complaints as he is not aware of overlapping patients with them. Petitioner further testified that he has never refused to coordinate care, but that he does not reach out to other physicians and the responsibility of coordinating care is on the PCP. He also described staffing issues that have affected his office's ability to seek prior authorizations.

Petitioner also testified that he has safeguards in place for treating certain patients, include drug screens, and that he will discharge them when necessary. He disagrees with Dr. Fletemier's allegations and the accuracy of her statements on standards of care, with a suspicion that she is a PCP while he is treating patients with substance abuse disorders. He is not aware of any complaint by Dr. Kates and noted that Dr. Kates has never reached out to him.

Petitioner further testified that his patients are adversely affected by this suspension because no one is prescribing for the substance abuse disorders like he does, though he does agree that he has no specific information about patients being affected.

Having considered the whole record and the parties' arguments in full, the undersigned Administrative Law Judge finds that the Department has established by competent, material, and substantial evidence on the whole record that the summary suspension was proper under 42 CFR 455.23 and MCL 400.111f.

The Department asserts, and Petitioner does not dispute, that Petitioner prescribing and having claims submitted to Medicaid for medically unnecessary or inappropriate medications would constitute fraud under 42 CFR 455.23 and the Medicaid False Claims Act; and allegations of such behavior both exist in this case and were forwarded to the Department by UPHP in a fraud referral.

For example, in 2020, an in-network physician who is employed at a recovery center and who provides Medication Assisted Treatment (MAT) services to patients reached out to the UPHP to express his concerns regarding Petitioner's prescribing habits with respect to controlled substances, including the amount and dosing of such substances. Similarly, another in-network physician, who was the primary care physician for plan members in UPHP's Benefits Monitoring Program (BMP), a program partly in place to closely monitor members who may be potentially over utilizing or misusing services and benefits, reached out to the UPHP to express her concerns with respect to Petitioner's prescribing habits, including unnecessarily or inappropriately prescribing controlled substances, and his refusal to coordinate care, which would require that Petitioner explain the prescriptions and have them reviewed by another physician. Moreover, a BMP Case Manager at UPHP also reported her concerns that, for multiple years and for multiple beneficiaries, Petitioner

was prescribing drugs that require prior authorization, but then refusing to request prior authorization from UPHP, which meant that beneficiaries were required to pay out of pocket and that the prescriptions would not be reviewed for medical necessity or appropriateness by UPHP. She further identified a third physician who would not approve Petitioner to prescribe medications for a patient.

Moreover, the allegations against Petitioner were also reviewed in light of past administrative actions involving Petitioner and, while certainly not dispositive, the history of substantiated complaints against Petitioner only strengthened the credibility of the new fraud allegations and the reasonableness of the Department's belief that a suspension was warranted. As noted in the fraud referral, and confirmed by the Department, in July of 2014, Petitioner and the Disciplinary Subcommittee of the Board of Medicine of the Bureau of Health Care Services of LARA entered into a Consent Order and Stipulation in which they agreed that the Disciplinary Subcommittee could treat the allegations of fact and law in a complaint against Petitioner as true and find that Petitioner's conduct while prescribing methadone, a schedule 2 narcotic, for multiple patients constituted negligence in violation of MCL 333.16221(a). Similarly, in February of 2020, Petitioner and the Disciplinary Subcommittee entered into a Consent Order and Stipulation in which they agreed that the Disciplinary Subcommittee could treat the allegations of fact and law in a complaint against Petitioner as true and find that Petitioner conduct while prescribing the medication Gabapentin, a drug known to be used and diverted, for multiple patients constituted negligence and departure from minimal standards of care in violation of MCL 333.16221(a) and (b)(i).

Finally, as noted by the Department, the fraud referral from UPHP was also forwarded on to the Michigan Department of Attorney General Health Care Fraud Division (HCFD) and the HCFD determined that an investigation was warranted, which only strengthened the credibility of the fraud allegations.

Petitioner accurately notes that the HCFD's investigation will be the first real investigation into the claims against Petitioner and that no one from UPHP or the OIG conducted an inquiry into the validity of the allegations, or even contacted Petitioner prior to the summary suspension; and that the Department's order took statements from the fraud referral verbatim and almost solely relied upon secondhand or thirdhand reports. Petitioner also testified himself and directly challenged the facts and opinions raised in the allegations against him, particularly the specific claims made in Dr. Fletemier's letter, and an investigation may have revealed inaccuracies or misstatements in those allegations.

However, Petitioner fails to point to any specific requirements, such as contacting the accused party for a response, for an investigation following a fraud referral or prior to issuing an order of summary suspension, and an extensive investigation would seem inappropriate given the nature of the temporary suspension at issue and the ongoing investigation. Moreover, the Department carefully reviewed the allegations it did have from multiple, independent medical professionals, in addition to Petitioner's past history and the initiation of an investigation by the HCFD; the standard for suspension in this

case is low, with the Department only having to determine that a fraud allegation is credible or that there is a reasonable belief that Petitioner violated the Medicaid false claims act, the health care false claims act, or a substantially similar statute of another state or the federal government; and that low standard was met considering the whole record.

Accordingly, while Petitioner did put forth evidence that might arguably weaken the Department's findings, the Department has met its low burden of establishing either that a credible allegation of fraud exists or that there is a reasonable belief that Petitioner violated the Medicaid False Claims Act and that emergency action was required to protect state Medicaid funds; and, consequently, the undersigned Administrative Law Judge finds that the summary suspension should be upheld.

IT IS THEREFORE ORDERED that:

- The Order of Summary Suspension issued by the Department to Petitioner on March 11, 2021 is UPHELD.