ISSUE

Whether the Department's March 29, 2021 Order of Summary Suspension is supported by competent, material, and substantial evidence on the whole record.

FINDINGS OF FACT

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

1. Petitioner is an enrolled provider in the State of Michigan's Medicaid program. (Respondent's [R's] Exhibit J, Part 13, pp 619-623; Testimony.)

2. On or about July 31, 2020, the Department received a complaint concerning Petitioner's practice from Patty Cornish, RN. (R's Exhibit J, Part 1, pp 24-26; Testimony.)

3. On August 6, 2020 and again on September 25, 2020, the Department referred the complaint to UPHP to conduct an audit of Petitioner's practice. (R's Exhibit J, Part 1, pp 22-23, 27-30; Testimony.)

4. On March 29, 2021, MDHHS issued an Order of Summary Suspension summarily suspending Petitioner's Medicaid enrollment effective March 31, 2021 based on findings contained in the audit conducted by UPHP and OIG. (R's Exhibit J, Part 1, pp 8-9; Testimony.)

5. Specifically, the Order of Summary Suspension alleged that Petitioner was "suspected of utilizing a physician assistant with a suspended license and an unlicensed non-clinician to provide the medical services billed to Medicaid." (R's Exhibit J, Part 1, p 8; Testimony.)

6. On March 1, 2021, the Department's OIG submitted the investigation report as a fraud referral to the Attorney General (AG) Health Care Fraud Division (HCFD). (R's Exhibit J, Part 1, p 12; Testimony.) On March 3, 2021, the AG HCFD accepted the Department's referral. (R's Exhibit J, Part 1, p 10; Testimony.)

7. Scott Martin Brown is the physician assistant (PA) alleged to have provided services to Petitioner's patients while his license was suspended. (R's Exhibit J, Part 13, p 606; Testimony.)

8. Scott Martin Brown's license to practice as a PA was suspended by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, for the periods of REDACTED, 2020 through REDACTED REDACTED, 2020 and REDACTED, 2020 through REDACTED 2020. (Petitioner's [P's] Exhibits 2, 3, 5, 6, and 7; Testimony.)

9. On April 12, 2020, Petitioner and Scott Martin Brown signed an Agreement

by which Petitioner agreed to supervise Petitioner's work, in order to comply with the Final Order reinstating Mr. Brown's license as a PA. (Exhibit 4; Testimony.)

10. Scott Martin Brown's name appears on the REDACTED 2020 medical records of Petitioner's patients J.D., M.S., and J.Q. (P's Exhibit 10; R's Exhibit J, Part 11, pp 371-377, 489-496, 518-523; Testimony.)

11. The procedure code G2086 or G2087 appears on the REDACTED 2020 medical records of Petitioner's patients J.D., M.S., and J.Q. Procedure codes G2086 and G2087 are used to bill for a full month of Office Based Opioid Treatment (OBOT), not a single encounter or patient visit. (P's Exhibit 10; R's Exhibit J, Part 11, pp 371-377, 489-496, 518-523; Testimony.)

12. Sindi Shortsle is a registered and certified Medical Assistant (MA) in Petitioner's practice. Melinda Shortsle is a registered and certified Medical Assistant in Petitioner's practice and also serves as the Office Manager for the practice. (R's Exhibit J, Part 13, pp 605-609; Testimony.)

13. Sindi Shortsle and Melinda Shortsle's names appear on the REDACTED 2020 medical records for Petitioner's patient A.G. (P's Exhibit 9; R's Exhibit J, Part 11, pp 530-533.) Petitioner did not bill Medicaid for any encounter with patient A.G. on REDACTED, 2020. (Testimony.)

14. On April 6, 2021, Petitioner filed a request for hearing. On April 7, 2021, a Notice of Hearing was issued, scheduling a Hearing for April 15, 2021. The April 15, 2021 hearing was adjourned and converted to a telephone prehearing conference per the parties' request. At the prehearing conference, a Zoom video hearing was scheduled for April 21, 2021. The April 21, 2021 hearing was adjourned per the parties' request and rescheduled for June 10, 2021. The June 10, 2021 hearing proceeded as scheduled and was continued and completed on June 16, 2021.

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)

Pursuant to the Social Welfare Act and the Petitioner's Medicaid Provider Agreement, Petitioner is required to follow all applicable Medicaid policy. *MCL 400.111a(1)*

A Medicaid provider must 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)

The Social Welfare Act of 1939, 1939 PA 280, (Act) as amended, provides for the summary suspension of Medicaid providers.

MCL 400.111f provides, in pertinent part:

> (1) <u>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</u>. Circumstances that warrant emergency action include, <u>but are not limited to</u>, any of the following:
>
> > (a) A reasonable belief, determined in accordance with professionally accepted standards, that rendered services for which a provider has submitted claims were medically unnecessary, inappropriate, or of inferior quality, and therefore that the continued participation in the program by the provider or payments to the provider for services constitutes a threat to the public health, safety, or welfare or to the health, safety, or welfare of recipient medically indigent individuals.

(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.

(d) A reasonable belief that 10% or $10,000.00, whichever is less, for a noninstitutional provider, or 10% or $50,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during the most recent 12-month period was unsubstantiated or was for services that were noncovered.

(e) A reasonable belief that 10% or $10,000.00, whichever is less, for a noninstitutional provider, or 10% or $50,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during the most recent 12-month period were medically unnecessary, inappropriate, or of inferior quality.

(f) A reasonable belief that 15% or $15,000.00, whichever is less, for a noninstitutional provider, or 15% or $75,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during a consecutive 12-month period, and that 5% or $5,000.00, whichever is less, for a noninstitutional provider, or 5% or $25,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted during the most recent 12-month period, was for services that were noncovered.

(g) A reasonable belief that 15% or $15,000.00, whichever is less, for a noninstitutional provider, or 15% or $75,000.00, whichever is less, for an institutional provider, of the provider's claims submitted at any time during a consecutive 12-month period, and that 5% or $5,000.00, whichever is less, for a noninstitutional provider, or 5% or $25,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted during the most recent 12-month period, was for services that were medically unnecessary, inappropriate, or of inferior quality.

(h) A reasonable belief that the provider is refusing to comply with section 111b(7), (19), or (25).

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(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(1)(a)-(h), (5), Emphasis added)

MCL 400.111d provides, in pertinent part:

(1) Participation as a provider in the program is subject to denial, suspension, termination, or probation on the grounds specified by section 111e. The director may take 1 or more of the following actions:

(a) Refuse to enroll an applicant.

(b) Suspend a provider indefinitely or for a term certain.

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MCL 400.111e provides, in pertinent part:

(1) The grounds for action by the director under section 111d(1) and the actions to which they may be applied shall be as follows:

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(5) In addition to or in place of the grounds specified in subsection (1), (2), or (3), the director may base an action provided for in section 111d(1)(a), (b), (c), (d), (e), or (f) on his or her judgment that the action is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program. (Emphasis added.)

The *Michigan Medicaid Provider Manual* governs termination of Medicaid Providers enrollments, including summary suspensions. It states as follows:

SECTION 6 – DENIAL OF ENROLLMENT, TERMINATION AND SUSPENSION

6.1 TERMINATION OR DENIAL OF ENROLLMENT

MDHHS may terminate or deny enrollment in the Michigan Medicaid program. Termination of enrollment means a provider's billing privileges have been revoked and all appeal rights have been exhausted or the timeline for appeal has expired. Denial of enrollment means the provider's application will not be approved for participation in the Medicaid program.

MDHHS must terminate or deny a provider's enrollment in Michigan's Medicaid program for the following reasons:

- Termination on or after January 1, 2011 under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state.

- Convicted of a relevant crime described under 42 USC 1320a-7(a):

  - Conviction of program-related crimes Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under subchapter XVIII or under any State health care program.

  - Conviction relating to patient abuse Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

  - Felony conviction relating to health care fraud Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph [1]) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement,

breach of fiduciary responsibility, or other financial misconduct.

- Felony conviction relating to controlled substance

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Providers who have been excluded due to one of the federal mandatory exclusions listed above will remain on the MDHHS Sanctioned Provider List until the minimum period for their exclusion has been completed and the provider has requested a lifting of their sanction from the sanctioning body.

- Failure to comply with the enrollment requirements of the Social Welfare Act, Public Act 280 of 1939 (MCL 400.111b -111e) and the provider screening and enrollment requirements pursuant to 42 CFR 455.416. The basis for termination or denial of enrollment under this section includes, but is not limited to, the provider's:
  - failure to submit timely and accurate information;
  - failure to cooperate with MDHHS screening methods;
  - failure to submit sets of fingerprints as required within 30 days of a CMS or MDHHS request;
  - failure to permit access to provider locations for site visits;
  - falsification of information provided on the enrollment application or subsequent information requests;
  - inability to verify their identity; or
  - failure to comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries.
- The provider is excluded from participating in a provider capacity in Medicare, Medicaid or any other Federal health care programs.
- The provider is convicted of violating the Medicaid False Claims Act, the Health Care False Claims Act, a substantially similar statute, or a similar statute by another state or the federal government.

- The provider has a federal or state felony conviction within the preceding 10 years of their provider enrollment application, including but not limited to, any criminal offense related to:
    - murder, rape, abuse or neglect, assault, or other similar crimes against persons;
    - extortion, embezzlement, income tax evasion, insurance fraud, and other similar financial crimes;
    - the use of firearms or dangerous weapons; or
    - any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
- The provider has a federal or state misdemeanor conviction within the preceding five years of their provider enrollment application, including but not limited to, any criminal offense related to:
    - any misdemeanor crime listed as a permissive exclusion in 42 USC 1320a-7(b);
    - rape, abuse or neglect, assault, or other similar crimes against persons;
    - extortion, embezzlement, income tax evasion, insurance fraud, or other similar financial crimes; or
    - any misdemeanor that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

For the purposes of the excluded offenses mentioned above, an individual or entity is considered to have been convicted of a criminal offense when:

- a judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending;
- there has been a finding of guilt against the individual or entity by a federal, state, tribal or local court; or
- a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal, or local court.

The criminal history screening will be conducted by MDHHS through reputable and reliable data sources. Screenings for providers will be done

as required by law and as deemed necessary by MDHHS for the protection of the Medicaid program and beneficiaries. For criminal offenses that fall under the mandatory exclusions of 42 USC 1320a-7(a), the definition of conviction will conform with 42 USC 1320a-7(i), which may include, but is not limited to, a record relating to criminal conduct that has been expunged.

Any entity that offers, in writing or verbally, discounts on co-pay amounts, fax machines, computers, gift cards, store discounts and other free items, or discounts/waives the cost of medication orders if an entity uses their services:

- may violate the Medicaid False Claim Act and Medicaid/MDHHS policy, which may result in disenrollment from Medicaid/MDHHS programs.

- may violate the Michigan Public Health Code's prohibition against unethical business practices by a licensed health professional, which may subject a licensee to investigation and possible disciplinary action.

Pursuant to MCL 400.111e, the Medicaid Director may terminate or deny enrollment if that action is necessary to protect the health of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program. Additionally, the Medicaid Director may reduce or extend a provider's exclusion from the Medicaid program if, in the Medicaid Director's judgment, the continuation or reduction of the exclusion period is necessary to protect beneficiaries or the Medicaid program.

Providers who are already enrolled at the time of a finding by MDHHS will have their enrollment ended as of the date MDHHS was notified of the excluded offense. Claims with dates of service on and after the provider's enrollment termination date will be denied.

6.2 ENROLLMENT AND REINSTATEMENT AFTER TERMINATION OR DENIAL

Providers who are excluded from participation in the Medicaid program due to conviction of a crime listed in the previous subsection may request enrollment or reinstatement upon a showing that the provider's participation is in the best interest of the Medicaid program and of Medicaid beneficiaries. Factors that may be considered when determining whether enrollment or reinstatement in the Medicaid program is in the best interest of the Medicaid program and beneficiaries includes, but is not limited to:

- whether the exclusion poses an undue hardship to beneficiaries;

- whether the provider is the sole community physician or sole source of specialized services in the community;

- subsequent offenses of the provider;
- amount of time that has lapsed since the excluded offense;
- whether all conditions, terms of probation or parole, penalties, fines, etc. of the felony or misdemeanor offenses that resulted in exclusion have been fully completed;
- provider's participation in Medicare or other state Medicaid programs; or
- other factors that demonstrate the provider does not otherwise pose a risk to the Medicaid program or beneficiaries.

Requests for reinstatement must be sent in writing to the Medicaid Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

MDHHS will address requests for enrollment and reinstatement within 30 days after all requested information has been provided.

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.

6.4 LOSS OF LICENSURE/LIMITED LICENSES

For providers who must be licensed to practice their profession, continued enrollment in Medicaid is dependent upon maintaining licensure. Failure to renew a provider's license results in disenrollment from Medicaid effective the date of final lapse of the provider's license.

Limited or suspended licenses may result in disenrollment or denial of enrollment if MDHHS determines the basis of the action to be detrimental to the health or safety of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program.

Suspension or revocation of a provider's license by the appropriate standard setting authority results in termination of Medicaid participation effective on the date the provider is no longer licensed. In the case of a provider not located in Michigan, suspension or revocation would be administered by the appropriate state licensing board.

If a provider is no longer licensed to practice (e.g., the license was suspended, lapsed, or revoked), MDHHS does not reimburse for services ordered, prescribed, referred or rendered by that provider after the termination of the license. Medicaid payments obtained for services rendered during a period when the provider was unlicensed must be refunded to the State.

A provider may submit an on-line application to MDHHS to request re-enrollment as a Medicaid provider when his license is reinstated. Refer to the Provider Enrollment Section of this Chapter for information on the enrollment process.

Medicaid Provider Manual
General Information for Providers Chapter
January 1, 2021, pp 16-20
Emphasis added

In addition, 42 CFR 455.23 provides for suspension of a Medicaid provider upon the finding of a credible allegation of fraud:

(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.

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(d) Referrals to the Medicaid fraud control unit.

(1) Whenever a State Medicaid agency investigation leads to the initiation of a payment suspension in whole or part, the State Medicaid Agency must make a fraud referral to either of the following:

(i) To a Medicaid fraud control unit established and certified under part 1007 of this title; or

(ii) In States with no certified Medicaid fraud control unit, to an appropriate law enforcement agency.

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(3)

(i) If the Medicaid fraud control unit or other law enforcement agency accepts the fraud referral for investigation, the payment suspension may be continued until such time as the investigation and any associated enforcement proceedings are completed.

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(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:

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(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.

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:

(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.

Emphasis added.

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.

Emphasis added.

As such, to support a summary suspension, the Department must show by competent, material, and substantial evidence on the whole record that there is a credible allegation of fraud under 42 CFR 455.23, that the summary suspension is necessary to protect the health of medically indigent individuals, the welfare of the public, or the funds appropriated for the Medicaid program under MCL 400.111e(5), or that there is an indication of fraud or Medicaid misuse/abuse under MPM Section 6.3.

UPHP's Internal Auditor testified that has worked as an auditor for five years and, as an auditor, she is charged with looking for fraud, waste, and abuse in the Medicaid program. UPHP's Internal Auditor indicated that UPHP is a managed care and provider service organization that provides health coverage to Medicaid beneficiaries, among others. UPHP's Internal Auditor testified that Petitioner's name came to her attention in August 2020 when UPHP received a letter from the Department's OIG instructing UPHP to audit Petitioner. UPHP's Internal Auditor testified that her office conducted an investigation and reported back to OIG in a written report.

UPHP's Internal Auditor testified that during the audit they determined that three of Petitioner's patients were seen by Petitioner's PA on REDACTED 2020, when his license was suspended. UPHP's Internal Auditor indicated that they also discovered that medical assistants were making patient calls on REDACTED 2020. UPHP's Internal Auditor indicated that at the time the audit was completed, Petitioner had not billed for any of the services provided on REDACTED 2020.

On cross examination, UPHP's Internal Auditor testified that the procedure code G2087 appears on all of the medical records involving Petitioner's PA for REDACTED 2020 and that this procedure code is used to bill for a month's worth of services, not one date of service during the month. UPHP's Internal Auditor admitted that when the Department's OIG first requested that UPHP audit Petitioner, UPHP refused, but when the Department made the request a second time, UPHP conducted the audit. UPHP's Internal Auditor also admitted that while she only asked Petitioner's office for medical records for seven patients, Petitioner's office provided medical records for 24 patients, or more than requested. UPHP's Internal Auditor also noted that Petitioner's office was under no obligation to send UPHP any records.

UPHP's Internal Auditor also admitted that she included in her findings a conclusion that Petitioner's PA provided services on June 10, 2020 when his license was suspended but it turned out that his license was not suspended on June 10, 2020. UPHP's Internal

Auditor explained that she relied on the letter from OIG regarding the suspension dates and did not verify the dates herself. UPHP's Internal Auditor testified that she believed medical services were provided on REDACTED 2020 because there were medical records for that date. UPHP's Internal Auditor admitted that she did not know what type of medical records would be created for ongoing opioid treatment. UPHP's Internal Auditor testified that she relied solely on the records provided to come to her conclusions and did not reach out to Petitioner or Petitioner's PA during the audit.

UPHP's Internal Auditor testified that at the end of the chart involving the "nurse visit/phone call" it indicates that the encounter was completed by Dr. REDACTED. UPHP's Internal Auditor also noted that there was no claim submitted for a nurse visit on REDACTED 2020 to Medicaid through UPHP.

The Department's OIG Manager testified that she has been with OIG for over 20 years and her Department oversees and investigates managed care entities in Michigan. The OIG Manager indicated that her area is responsible for detecting Medicaid fraud and, if fraud is found, a referral is made to the AG's HCFD and payments to the provider are suspended as required under the CFR's. The OIG Manager indicated that the audit process depends on the source of the complaint, i.e., if the complaint comes from a managed care organization, OIG reviews the information and also submits the matter to the AG's HCFD.

The OIG Manager testified that Petitioner came to her attention in January 2021 after the UPHP audit was completed. The OIG Manager indicated that Petitioner's PA's license was suspended from July 27, 2020 to August 4, 2020 but they saw medical records with his name on them with a date of REDACTED 2020. The OIG Manager indicated that she also looked to see if either Sindi or Melinda Shortsle had any clinical licensure to see patients and determined that they did not. The OIG Manager testified that OIG also sent the referral to the AG's HCFD and the referral was accepted. The OIG Manager also noted it was of concern that Petitioner had billed over $5 million dollars in prescriptions to Medicaid between 2016 and 2020. The OIG Manager testified that the fact that the AG's HCFD accepted the referral and began an investigation of Petitioner was another factor in the decision to suspend Petitioner from the Medicaid program.

The OIG Manager testified that pursuant to the MPM Practitioner Chapter, Section 1.7, the care and treatment of Medicaid beneficiaries can only be delegated when a physician is present. The OIG Manager testified that a PA must also be licensed to see patients and, if they are not licensed, that would constitute fraud, regardless of whether a claim was submitted to Medicaid for the services. The OIG Manager noted that while a medical assistant can provide some services, such as taking blood pressure or a medical history, if the service requires a clinical practitioner, then a MA could not provide the service.

The OIG Manager testified that OIG determined here that there was a credible allegation of fraud and issued an Order of Summary Suspension to Petitioner. The OIG Manager testified that if a credible allegation of fraud is found, a suspension is mandatory. The OIG Manager noted that Petitioner was also suspended under the Social Welfare Act, which is discretionary, and requires only a reasonable belief of fraud. The OIG Manager

testified that OIG reviewed all the evidence carefully, that there was an indicium of reliability to the evidence, and that the investigation by the HCFD is still ongoing. The OIG Manager noted that OIG does not have to determine that actual fraud occurred to issue a summary suspension, only that there was a credible allegation of fraud.

On cross examination, the OIG Manager confirmed that in the Order of Summary Suspension, under the Social Welfare Act portion, it only indicates that the suspension was necessary to protect public funds, not the health and welfare of Medicaid recipients. The OIG Manager also confirmed that while the Order of Summary Suspension mentions a violation of the Medicaid False Claims Act, there was no allegation here that Petitioner violated that Act. The OIG Manager admitted that there must be some type of monetary benefit before fraud can be found and that she did not know whether there was any monetary benefit to Petitioner here.

The OIG Manager testified that she checked the licensure status of Petitioner's PA and that it appeared from the medical records that he saw three patients on REDACTED 2020 when his license was suspended. The OIG Manager indicated that she had not seen a chronic care management chart before, and she was not aware what the billing code appearing on the charts meant. The OIG Manager admitted that in the audit report from UPHP, it indicated incorrectly that Petitioner's PA was suspended on June 10, 2020.

Regarding the nurse visit/phone call on REDACTED 2020, the OIG Manager testified that she did not know what the billing procedure code for a nurse visit was and that this encounter was not billed to Medicaid. The OIG Manager also admitted that the first part of the chart including the patient histories included all information that a medical assistant could take from a patient. The OIG Manager indicated that the medical services provided by the medical assistant occurred under the Assessment and Plan heading where it indicates that the patient was started on Gabepentin and that a medical assistant cannot start a patient on a new medication. The OIG Manager admitted that the chart does indicate at the end that the encounter was completed by REDACTED REDACTED, but it was unclear to her if he was involved because there is no date, time or signature next to his name. The OIG Manager admitted that she did not check the actual prescription to see who wrote it. The OIG Manager testified that even though under history it indicates the patient has been taking this medication and doing well on it, she read the chart to mean that the medical assistant started the patient on a new medication.

Regarding her concern about the millions of dollars billed to Medicaid for prescriptions by Petitioner from 2016 to 2020, the OIG Manager admitted that the number one medication on the list was for the shingles vaccine, followed by a number of other biologicals. The OIG Manager admitted that she did not know that Petitioner was the doctor on the standing order for vaccines at a number of local pharmacies. The OIG Manager did admit that UPHP found no issue in its report with the amount of prescribing Petitioner did. The OIG Manager also admitted that the amount of prescriptions billed for office visits and suboxone during the time in question was only approximately $28,000.

The OIG Manager testified that the dates in question were during the COVID-19 pandemic and that there were emergency orders in effect regarding numerous

businesses, including doctor's offices, that limited in-person interactions. The OIG Manager admitted that she did not know if Petitioner's office was open and seeing patients in-person during the pandemic or whether everything was being done virtually.

Petitioner's Medical Assistant (MA) testified that she has worked at Hope Primary & Urgent Care in Big Rapids, where Petitioner is the medical director, for three years. Petitioner's MA testified that she completed schooling to be an MA, completed a five-week externship and then had to pass two tests to become a certified and registered MA. Petitioner's MA testified that one of her duties as an MA is to take patient histories.

Regarding the phone call with patient A.G. on REDACTED 2020, Petitioner's MA testified that she was asked to call the patient because the patient was due for a medication refill. Petitioner's MA testified that her name appears in the patient's medical records because she either took the information and entered it into the chart or pulled the information forward from prior charts. Petitioner's MA testified that she asked the patient how she was doing, whether the medication was working, and whether she needed a refill. Petitioner's MA testified that she did not know why Melinda Shortsle's name (the Office Manager) appeared under the Plan and Assessment portion of the chart. Petitioner's MA testified that she did not do an assessment, develop a care plan, diagnose the patient, determine what medications she should be on, or start or restart the patient on any medications on REDACTED 2020. Petitioner's MA testified that she only talked to the patient to get a history and see if she needed a refill, then the prescriber (Petitioner) determined whether to refill the prescription. Once the prescriber authorized the refill, Petitioner's MA testified that she called it in to the pharmacy.

On cross examination, Petitioner's MA indicated that the name, the date, and the time that appear next to each section of the chart reflects the last person that clicked on that section. Petitioner's MA noted that your name, the date and the time will appear even if you do not change anything in a particular section of the chart. Petitioner's MA opined that Melinda Shortsle's name may appear under the Assessment and Plan because she may have updated that section.

Petitioner's Office Manager testified that she has also worked at Hope Primary & Urgent Care in Big Rapids for three years and that she is the office manager and a certified, registered medical assistant. Petitioner's Office Manager testified that she completed a fast track eight-month course to become a medical assistant, followed by a five-week externship. Petitioner's Office Manager testified that the practice uses All Scripts as the software program for its electronic health records and she is familiar with how it operates. Petitioner's Office Manager testified that as a MA she is trained to take patient histories and enter information in patient charts, even if that information is not collected by her. Regarding patient A.G. on REDACTED, 2020, Petitioner's Office Manager testified that her name may appear under the Assessment and Plan because she went into the chart to get the diagnosis to give to the medical biller. Petitioner's Office Manager testified that she did not assess the patient, did not do a care plan, and did not do anything for that patient on that day. Petitioner's Office Manager testified that she never assesses patients, develops care plans, determines medications, or prescribes medications. Petitioner's Office Manager noted that the Clinical Summary at the end of the chart is the

patient's copy and her name appears on that because she printed it out (for the audit) and was the last person in the chart.

On cross examination, Petitioner's Office Manager testified that her name should appear on all of the Clinical Summaries in the charts provided for the audit because she printed them all out but admitted that Petitioner's PA's name appeared on the M.S. Summary so maybe that was not true.

Petitioner's PA testified that he has been a licensed PA in Michigan since 1996 and received his training and education at Western Michigan University. Petitioner's PA indicated that he specializes in the care of patients with substance abuse disorders and has done so since 2013. Petitioner's PA testified that he is a core trainer specializing in recovery and participates as an advocate in a national organization focusing on substance abuse treatment.

Petitioner's PA testified that he began working with Petitioner in early April 2020 and that his license was in effect at that time. Petitioner's PA indicated that his license was suspended REDACTED 2020 but that suspension was lifted on REDACTED 2020. Petitioner's PA testified that one of the conditions to get his license reinstated was to have a physician oversee his work and Petitioner agreed to do so. (See P's Exhibit 4.) Because Petitioner's PA began working for Petitioner during the COVID-19 pandemic and all work was done remotely, the Agreement states that all interactions between Petitioner's PA and patients would be recorded and Petitioner would then review the recordings.

Petitioner's PA testified that he was interested in working for Petitioner because Petitioner also had an interest in substance abuse disorder treatments and the use of suboxone. Petitioner's PA indicated that a new program he began at Petitioner's practice, called Office Based Opioid Treatment (OBOT) allows primary care physicians such as Petitioner to treat substance abuse disorders within the practice instead of referring those patients out to specialists. Petitioner's PA testified that the OBOT is a relatively new program, and it has its own billing/procedure codes: G2086 for the first month of treatment and G2087 for each subsequent month of treatment. Petitioner's PA testified that the treatment could include many services throughout the month in addition to suboxone, but the services are billed at the end of the month using the above referenced procedure codes. Petitioner's PA testified that the program was addressed in MSA Bulletin 20-01 in January 2020.

Petitioner's PA testified that his license was suspended briefly from REDACTED 2020 through REDACTED 2020 because he forgot to pay the fine from his reinstatement in April 2020. Petitioner's PA indicated that the suspension had nothing to do with his clinical behavior or professional conduct. Petitioner's PA reviewed the letter he received from the Bureau of Professional Licensing regarding the suspension and failure to pay the fine (Exhibit 6) and the letter received once the fine was paid, and the suspension was lifted (Exhibit 7). Petitioner's PA testified that he had no patient encounters from July 27, 2020 through August 4, 2020, he did not treat any patients in-person, by video, or by telephone and did not provide any medical care services at all. Petitioner's PA testified that when the suspension was lifted August 4, 2020, he did not immediately begin seeing patients

again because Petitioner wanted to wait until the suspension showed lifted on LARA's website.

Petitioner's PA reviewed Exhibit 10, which is the REDACTED, 2020 chart for patient M.S. Petitioner's PA indicated that he did not see M.S. on that date, had no contact with her and did not provide any services to her. Petitioner's PA indicated that the purpose of the chart was to bill for OBOT services at the end of the month. Petitioner's PA indicated that for OBOT, the services performed during the month are gathered at the end of the month and entered using the aforementioned billing codes. Petitioner's PA testified that this is basically just a charting mechanism to bill for the OBOT services performed throughout the month and there is no contact with the patient. Petitioner's PA testified that you could tell from the date and time stamps in the chart that he did not see the patient because each section of the chart is time stamped at the same time (4:36) and then the Assessment and Plan is time stamped just a few minutes later at (4:39). Petitioner's PA explained that if this were an actual office visit there would be greater gaps on the timestamp between each section as he spoke with the patient and added information to each section. Petitioner's PA noted that at the end of the chart the billing code G2086 is plainly visible to anyone reviewing the chart.

Petitioner's PA reviewed the charts of patients J.Q. and J.D, which were also charts created to bill for OBOT on REDACTED, 2020. Petitioner's PA noted that you cannot enter a patient chart, even just to do the OBOT billing, without creating an encounter, which is why each chart indicates "Office Visit" at the top. Petitioner's PA testified that he has worked with All Scripts staff to correct this, but as of yet they have not found a solution.

On cross examination, Petitioner's PA agreed that a PA must be licensed to provide medical care and if he had provided care while not licensed that would have been improper. Petitioner's PA indicated that OBOT treatment requires at least 60 minutes of interaction within the month and that those services could be provided all on one day or on several days throughout the month. Petitioner's PA testified that he is no expert on the All Scripts software program but did try to work with them to find a solution to the encounter issue when entering month end billing for OBOT. Petitioner's PA testified that it is not possible that he saw patients during his suspension period in the summer of 2020. Petitioner's PA indicated that he is very careful with his license as he has been in substance abuse treatment himself for 10 years.

Petitioner's PA testified that it would not be reasonable for someone reviewing these charts to conclude that he saw these patients on REDACTED, 2020 because the charts clearly contain the G2086 or G2087 billing codes for OBOT end of month billing. Petitioner's PA noted that this is not an office visit code and could not be mistaken for an office visit code. Petitioner's PA also noted that if he had been doing office visits on REDACTED, 2020 there would have been recordings of all the visits as required by his Supervision Agreement and there were no such recordings from that date. Petitioner's PA testified that a list of encounter codes in the patient's chart does not mean that the patient was seen on each date listed. Petitioner's PA noted that for each patient, the list of encounters includes a date at the end of the month that would have been the date OBOT was billed.

Petitioner testified that he received his medical degree overseas in 1996 and completed an internship in 1998. Petitioner indicated that he came to the U.S. and worked at U of M until 2008, then went to another medical school to obtain his M.D. Petitioner testified that he then completed his residency at McLaren in 2013 and has been practicing family and emergency medicine since 2015. Petitioner testified that he is board certified in family medicine and has practiced in multiple ER's and inpatient hospitals. Petitioner indicated that prior to April 2020 he worked 10 days as an ER doctor in Kentucky and then supervised the urgent care practice in Big Rapids on the other days.

Petitioner testified that the clinic in Big Rapids served primary care and walk in patients and had previously been run by a nurse practitioner. Petitioner testified that the practice had a lot of chronic care patients not accepted by other providers, including a number of former and current drug abusers. Petitioner testified that he applied for a waiver to prescribe suboxone, which was granted in March 2020.

Regarding the nearly $5 million in prescription billings between 2016 and 2020, Petitioner testified that the vast majority of those billings were for vaccines, including pneumonia, shingles, and HPV, as Petitioner's name was on the standing order for vaccines at numerous local pharmacies.

Petitioner indicated that he was aware of the PA's licensure status before hiring him and also agreed to supervise the PA as required by the supervision agreement. Petitioner testified that the PA had his own patients from a prior practice with substance abuse issues that he brought with him to Petitioner's practice. Petitioner testified that he approved and signed off on the plan of care for every patient involved in the audit. Petitioner testified that the PA could not make any changes to care plans without his review and that if a patient's medication changed, then he, the physician, had to prescribe that medication, not the PA.

Petitioner testified that the practice uses All Scripts as its electronic health record software program, and he has become familiar with the program over time. Petitioner noted that even if the PA's name appears in a chart, he has to sign off on the chart as part of the supervision requirement. Petitioner testified that on REDACTED, 2020 he received multiple calls from the practice because the PA was scheduled to see patients (via video) that day, but the PA did not show up for the video appointments. Petitioner indicated that he had to jump in and handle the situation. Petitioner testified that some of the patients had to be rescheduled and some of the patients he saw. Petitioner indicated that he had the staff call the patients who were scheduled who might need refills on their medications and he then ordered those refills as needed. Petitioner testified that it was at this time that he learned about the PA's license suspension. Petitioner testified that he allowed the PA to work on end of month billing for the OBOT program on REDACTED, 2020 but did not let him see any patients.

Petitioner testified that when the PA showed him the letter from LARA indicating that his license suspension was lifted, he checked the LARA website, but the website still showed the suspension. Petitioner indicated that he informed the PA that he would have to wait for the LARA website to be updated before he could see patients because he did not want

patients seeing the PA and then checking the website and seeing the suspension. Petitioner noted that it took a few days for the LARA website to be updated and he did not allow the PA to see patients during those days either. Petitioner testified that the PA had no patient encounters between July 27, 2020 and August 4, 2020.

Petitioner reviewed Exhibit 13, which is a copy of the practice's daily schedule for REDACTED, 2020. Petitioner pointed out that for the chronic care management patients on the schedule for that day, i.e., the OBOT patients who were not actually seen, the check in and check out times are the same. Petitioner testified that this is so because All Scripts does not allow anyone to enter anything in the electronic health record without creating an encounter. Petitioner testified that for chronic care patients, they must be entered on the schedule at the end of the month in order to complete the end of month billing.

Petitioner testified that for patient A.G., who was on the schedule to see the PA on REDACTED, 2020, he had the MA call the patient to see if she needed a refill and then refilled the medications after the phone call. Petitioner testified that he instructed the staff specifically not to bill for this phone call and his practice never billed for this phone call. Petitioner testified that he has reviewed the chart of A.G. for REDACTED, 2020 and it is consistent with what he instructed the staff to do.

Petitioner testified that once the summary suspension was filed, he could not write prescriptions for his patients. Petitioner indicated that he has many patients with chronic conditions, and he had to work with other doctors in the community to get prescriptions written for those patients. Petitioner testified that the Big Rapids area is an underserved area and there is a shortage of suboxone prescribers in the area. Petitioner indicated that the suspension has had an adverse impact on his patients, and many went days without medications. Petitioner testified that the clinic is currently closed due to the summary suspension.

On cross-examination, Petitioner agreed that he is ultimately responsible for the software program he decides to use in his practice. Petitioner also agreed that MA's are allowed to perform some services in a medical practice but not others. Petitioner reviewed the charts in question and testified that the fact that the PA's name is on the charts does not mean that he saw patients that day, it just means he accessed the patients' charts that day. Regarding the A.G. chart for REDACTED, 2020, Petitioner testified that the only new information in that chart was under the history of present illness and that all the other information in the chart on that day was just pulled forward from the face sheet, which includes all information that he previously approved. Petitioner agreed that he was not physically present for some of the care and treatment of patients but indicated that because of the pandemic no-one was physically present for care and the office was actually closed. Petitioner indicated that on REDACTED, 2020 he was working at home, as were the PA, the MA's, and the entire office staff.

The record establishes that Petitioner is an enrolled Medicaid Provider and executed an application agreement in which he agreed to adhere to all the terms and conditions listed therein.

In this case, the Department argues that the evidence presented supports its summary suspension action. In support, the Department relies on the audit conducted by UPHP and OIG which determined that a physician assistant in Petitioner's practice saw patients while his license was suspended and that non-medical personnel in the office provided medical services to Petitioner's patients. UPHP concluded that a physician assistant provided medical services while suspended because a PA in Petitioner's office appeared on medical records for at least three patients on REDACTED, 2020, a date when his license was suspended. UPHP concluded that non-medical personnel in the office provided medical services to a patient because the names of two medical assistants in Petitioner's office were the only names on the medical record for a patient on REDACTED, 2020.

The Department argues that it properly relied on the audit by UPHP and OIG and that the allegations in that audit demonstrate a credible allegation of fraud that has been referred to and accepted by the Attorney General Health Care Fraud Division for further investigation. As such, the Department argues that they are required under 42 CFR 455.23 to suspend under those circumstances. The Department also argues that the Order of Summary Suspension was necessary to protect the funds appropriated for the Medicaid program, as contemplated in MCL 400.111e(5) and MCL 400.111f(1).

Petitioner argues that the conclusions reached by UPHP in the audit are factually incorrect and that the Department failed to review the evidence carefully and act judiciously as required under 42 CFR 455.2 before taking action against Petitioner. Petitioner argues that Scott Brown did not see any patients on REDACTED, 2020 but simply completed end of the month paperwork for billing purposes. Petitioner further argues that the medical assistants did nothing improper on REDACTED, 2020 when contacting a patient regarding a medication refill, and even assuming it was improper for an MA to contact a patient, the encounter was not billed so it cannot be considered fraud. Petitioner argues that the Department does have discretion on whether to suspend a provider under 42 CFR 455.23(d)(3) and the Department has failed to support its action by competent and material evidence on the whole record.

Having considered the whole record as well as the parties' arguments in full, the Department has failed to establish by competent, material, and substantial evidence on the whole record that its summary suspension was proper under the Social Welfare Act (MCL 400.111d(1), MCL 400.111e(5), and MCL 400.111f(1)), the MPM, or under the Federal Regulations (42 CFR 455.23).

As indicated above, under the Social Welfare Act, the Department must demonstrate that there is a reasonable belief that emergency action is necessary to protect the funds of the Medicaid program.[1] The sections of the Social Welfare Act regarding summary suspensions are also incorporated into the MPM, Section 6.3 of the General Information for Providers Chapter. That Section allows the Department to use as a basis for summary

[1] The Department did not allege in the Order of Summary Suspension that the action was necessary to protect the health of medically indigent individuals or the welfare of the public. Even if the Department had made such an allegation, it would not have changed the outcome of this Decision.

suspension "an indication of fraud or Medicaid misuse/abuse." Under the Federal Regulations, the Department must demonstrate that 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." 42 CFR 455.23(a)(1). "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." 42 CFR 455.2(3), Emphasis added.

Here, while there was an allegation of fraud made against Petitioner and his practice, that allegation was not credible after a careful review of the whole record. First, the fraud referral from UPHP began with a finding that Petitioner's PA was suspended on June 10, 2020 and provided services on that date. This finding was factually incorrect as Petitioner's PA was never suspended on June 10, 2020. This mistake should have put the Department's OIG on notice that it needed to review UPHP's conclusions very carefully. However, for the reasons stated below, it does not appear from the record that the Department's OIG reviewed the records carefully.

First, for the "nurse visit/phone call" conducted by Petitioner's MA for patient A.G. on REDACTED 2020, it is clear from the whole record that Petitioner's MA simply contacted the patient to see if she needed a refill of her medication as instructed by Petitioner. The MA updated the patient's history for purposes of the medication refill, and then forwarded the chart to Petitioner to approve the refill. And, if the Department had looked at the rest of A.G.'s medical records, which were provided to UPHP, it would have seen that the rest of the information in the chart entry for REDACTED, 2020, including the Assessment and Plan which had another MA's name in the date stamp, was simply pulled forward, verbatim, from prior entries in the chart. In addition, the Department could have looked at the prescription itself, which was available in MAPS, to confirm that it was Petitioner who wrote the prescription, not one of the MA's. As Petitioner argues, pulling one page out of an entire electronic medical record does not constitute a careful review for audit purposes.

Second, for the REDACTED, 2020 chart entries by Petitioner's PA, it is clear from the records reviewed by UPHP and the Department that these were not chart entries for patient visits. Instead, these charts are clearly marked with the billing/procedure code G2086 or G2087, which represents a month's worth of billing for OBOT. There was an MSA Bulletin available to the Department regarding the implementation of these codes and the Department could have simply looked at other entries in the medical records for patient visits to see that those charts looked entirely different (and, of course, had different billing/procedure codes for office visits). In addition, the time stamps on some of these charts are late in the evening, which should have been evidence to UPHP and the Department that these charts were likely not for office visits and further investigation was necessary. In addition, the time stamps on all of the charts were at the same time or very close to the same time, which would not have been the case with an actual office visit.

Third, none of the actions alleged to be fraudulent were billed to the health plan or to Medicaid. As indicated above, "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." 42 CFR 455.2 Emphasis added. Here, given that none of the alleged fraudulent actions were billed to Medicaid, it cannot be said that the deception, if there had been any, could have resulted in a benefit to Petitioner or anyone else.

Fourth, the Department's argument that it had no discretion but to suspend Petitioner from the Medicaid program because the matter has been referred to and accepted by the AG's HCFD is incorrect. As indicated above, 42 CFR 455.23(3)(i) indicates, "If the Medicaid fraud control unit or other law enforcement agency accepts the fraud referral for investigation, the payment suspension may be continued until such time as the investigation and any associated enforcement proceedings are completed." As such, the decision to suspend is discretionary even though the matter has been referred to the AG's HCFD. In addition, 42 CFR 455.23(e)(3) also contemplates the Department not suspending Medicaid payments upon a finding of good cause, such as the submission of written evidence that the suspension should be removed. Here, based on the evidence presented, it would appear that there is good cause to remove the suspension. Finally, while Section (1) of 42 CFR 455.23 indicates that the Department "must" suspend, that instruction only applies if there is a credible allegation of fraud, which is lacking here.

Fifth, the fact that Petitioner's office provided more records than requested by UPHP tends to lend credibility to Petitioner and his staff. It would be unlikely that someone knowingly engaged in fraud would provide more records than requested by an auditor.

Sixth, the Department's assertion that the nearly $5 million in prescriptions Petitioner billed to Medicaid from 2016 to 2020 was a factor in its decision to suspend Petitioner from Medicaid lacks merit given that it turns out the vast majority of those prescriptions were for vaccines. As indicated, Petitioner's name appeared on the standing order for vaccines at numerous local pharmacies, a fact that UPHP recognized and found no issue with but seemed suspicious to the Department's OIG. If Petitioner had billed Medicaid for $5 million dollars in suboxone over a four-year period, the Department might have a point, but that is clearly not the case here and that fact was evident on the fact of the documents the Department reviewed.

Seventh, the Department's reliance on MPM Practitioner Chapter, Section 1.7, which indicates that the care and treatment of a Medicaid beneficiary can only be delegated when a physician is present is without merit because the audit here occurred during the global COVID-19 pandemic. Numerous orders, first by the Governor and then by the Director of MDHHS, placed numerous restrictions on in-person interactions, including in doctor's offices, and removed requirements for in-person interactions throughout all segments of society. As such, the fact that Petitioner, his PA, his MA's and his office staff were working from home at the times relevant to the audit cannot form a basis for a summary suspension.

In conclusion, based on the entire record, the Department has failed to show by competent, material, and substantial evidence that there was a reasonable belief that

emergency action was necessary to protect Medicaid funds under the Social Welfare Act, that there was an indication of fraud or Medicaid misuse/abuse under the MPM, or that there was a credible allegation of fraud under the Federal Regulations to support the Order of Summary Suspension. As such, the Summary Suspension was improper and should be reversed and dissolved.

IT IS THEREFORE ORDERED that:

> The Order of Summary Suspension issued by the Department on March 29, 2021, effective March 31, 2021, is REVERSED and DISSOLVED.