

## **ISSUE**

Whether the Department properly issued an Order of Summary Suspension to Petitioner on March 29, 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 November of 2014, Petitioner has been an enrolled provider in in the Michigan Medicaid Program. (Exhibit C, pages 1-5; Testimony of Petitioner).
2. On January 6, 2020, a fraud referral was submitted to the Ohio Department of Medicaid with respect to Petitioner by a Medicaid Health Plan. (Exhibit B, pages 1-2).
3. The specific allegation in the fraud referral was:

This provider practices in Detroit, Michigan, at least an hour's drive from any of the members. Members are being prescribed opioids and muscle relaxants, however, the provider has not submitted any claims for office visits.

*Exhibit B, page 1*

4. The referral also noted:

This provider lost his license in Ohio and California because he did not disclose that his license to practice in the United Kingdom had been suspended. The state of Michigan fined him for the same offense. In the UK, Dr. REDACTED was suspended for 6 months for unsatisfactory patient care. He is currently not licensed in the UK.

*Exhibit B, page 2*

5. During the process in Ohio completed with respect to that fraud referral, the information in the referral was shared with Aetna Better Health of Michigan (ABH-MI) by Aetna's Ohio plan. (Exhibit A, page 1).
6. ABH-MI then opened an investigation into Petitioner. (Testimony of Senior SIU Investigator).
7. As part of that investigation, ABH-MI reviewed patient records in Michigan

and found cases where it paid claims for prescriptions written by Petitioner, but not any claims for corresponding office visits with Petitioner. (Testimony of Senior SIU Investigator).

8. ABH-MI also requested, and received, medical records from Petitioner's former employer. (Testimony of Senior SIU Investigator).
9. The records were then reviewed by a Medical Director at ABH-MI, who raised concerns about Petitioner's treatment of patients in a written report. (Testimony of Senior SIU Investigator).
10. No patients were contacted. (Exhibit A, pages 1-3; Testimony of Senior SIU Investigator).
11. On September 4, 2020, ABH-MI contacted Petitioner's current practice and requested medical records for patients. (Exhibit A, page 3; Testimony of Senior SIU Investigator).
12. The Senior SIU Investigator and Petitioner also spoke on the telephone, and Petitioner agreed to have the records sent. (Testimony of Petitioner; Testimony of Senior SIU Investigator).
13. No records were sent. (Testimony of Petitioner; Testimony of Senior SIU Investigator).
14. In early November of 2020, approximately thirty days after Petitioner indicated that he would send the records, the Senior SIU Investigator again contacted Petitioner over the telephone, with Petitioner subsequently stating that he had discarded the medical records request and needed it to be faxed again. (Exhibit A, page 3; Testimony of Senior SIU Investigator).
15. On November 12, 2020, ABH-MI's Special Investigations Unit (SIU) faxed Petitioner another letter requesting medical records from Petitioner. (Exhibit 4, pages 1-4).
16. In part, that letter stated:

We are conducting a review of services rendered to the patients on the attached sheet. I am writing to request the medical records for the time period indicated. Aetna Better Health of Michigan is permitted to obtain these records from you without obtaining additional authorization from the member/insured, because we are both "covered entities" as defined by HIPAA. Specifically, 45 CFR 164.502(a) allows such disclosures for "treatment, payment or health care operations."

\* \* \*

Please send the requested medical records to my attention by 12/01/2020. Thank you for your cooperation.

*Exhibit 4, pages 1-4*

17. On November 13, 2020, the Senior SIU Investigator and Petitioner again spoke over the telephone and, during that conversation. Petitioner indicated that he would not be sending over the records and that the investigator should contact Petitioner's attorney if she had any further questions. (Exhibit A, page 3; Testimony of Petitioner; Testimony of Senior SIU Investigator).
18. On November 16, 2020, ABH-MI sent a fraud referral to the Department's OIG with respect to Petitioner. (Exhibit A, pages 1-3).
19. With respect to the "Suspected Fraud Referral Details" the fraud referral stated:

In January 2020, The Ohio Department of Medicaid received a referral from Paramount Health Care due to the provider prescribing habits. Referral stated, "members are being prescribed opioids and muscle relaxants; however, the provider has not submitted any claims for office visits". This information was then shared with Aetna Better Health through the Ohio deconfliction process.

Aetna's investigator reviewed internal data for the period of 2017-2020 and found no claims for office visits; however, there were hundreds of claims for prescriptions for Aetna Medicaid members. Investigator pulled data for an earlier period of 2015-2016 and found 97 claim lines for office visits related services. However, these were under different offices (Midwest Medical Center, Michigan Neurology Associates and Molina Medical Group) that Dr. REDACTED worked in during the aforementioned period.

There were claims from Midwest Medical Center which were denied. The investigator requested medical records from Michigan Neurology (No Medicaid exposure) and Midwest Medical Center. Request for Midwest Medical Center was returned due to the provider was no longer at the listed address. No

medical records were requested from Molina due to there was only 1 record in the data.

*Exhibit A, pages 1-2*

20. With respect to the "Factual Explanation of suspected fraud/abuse, the referral stated: "Provider will not submit medical records to substantiate the pharmacy claims." (Exhibit A, page 2).
21. With respect to the section where the plan was to "[d]escribe results of audit / record review (i.e., the risks identified, cite specific billing codes if available)", the referral stated:

Medical records were received from Michigan Neurology Associates for the members treated by Dr. REDACTED and reviewed by the medical director and pharmacy manager. While there was no Medicaid exposure under Michigan Neurology Associates there were some alarming findings regarding the provider's prescribing habits for another line of business.

Concerns:

- There were no therapy notes or other conservative treatments documented in detail in the records for the purpose of weaning Opioids
- There is no evidence of dose titration or weaning with a plan of care for eventual discontinuation of treatment.
- Claims data show that the majority of prescriptions written by this provider are clinically reserved or recommended for acute care by CDC pain management guidelines. These guidelines do not recommend treatment with opioids for greater than 6 months for chronic conditions. Members seen by this provider have been on opioid treatment for greater than six months.

After reviewing the results of the medical review, the investigator requested additional records from the prescription claims with Medicaid exposure. Investigator contacted the provider's current office and spoke with Vijaya who confirmed the provider was only practicing at the Detroit location. She provided the fax number to send the medical records request and the

medical records request was sent on 09/04/2020.

Dr. REDACTED called the investigator and explained he does not bill Aetna Better Health of MI and will not send in medical records. Investigator explained Aetna Better Health of MI members were prescribed medications from the provider and we would like to review the medical records associated with the treatment of the members. Dr. REDACTED stated he would mail in the medical records. The medical records were not received, a follow-up call was made to the provider's office Dr. REDACTED stated he discarded the medical records request and requested the medical records request to be faxed again. Medical records request was faxed on 11/12/2020 to the provider's fax as requested. Dr. REDACTED called the investigator on 11/13/2020 and stated he would not send in the requested medical records and any further questions should go through his attorney.

*Exhibit A, page 3*

22. A copy of the fraud referral was also sent to the Michigan Department of Attorney General Health Care Fraud Division (HCFD). (Exhibit D, page 1).
23. The Department's OIG reviewed the fraud referral, but it did not conduct an independent investigation into its contents. (Testimony of Section Manager).
24. It did confirm that Petitioner is a Medicaid-enrolled provider and pulled claims to see his impact on the Medicaid program. (Testimony of Section Manager).
25. On December 30, 2020, the OIG also sent correspondence to the HCFD and asked it to respond within 30 days whether the HCFD "accepts, declines, or submits this referral back to Aetna for further development." (Exhibit D, page 1).
26. The OIG further 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 D, page 1).
27. On February 16, 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 E, page 1).

28. On March 29, 2021, the Department issued an Order of Summary Suspension with respect to Petitioner. (Exhibit A. pages 1-3).

29. 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 1669764627, and such evidence includes but is not limited to:

1. It is suspected that REDACTED wrote prescriptions for opioids and muscle relaxants that were in violation of the Centers for Disease Control (CDC) guidelines and paid for by Medicaid.
  - a. Hundreds of claims for these prescriptions were paid by Medicaid in 2017 through 2020 without a corresponding office visit billed for REDACTED to evaluate the patient for medical necessity of those opioids and muscle relaxants.
  - b. A review medical records obtained for office visits billed in 2015 and 2016 revealed the following alarming findings for the provider's prescribing habits:
    - i. No therapy notes or other conservative treatments were documented in detail in the records for the purpose of weaning opioids.
    - ii. No evidence of dose titration or weaning with a plan of care for eventual discontinuation of treatment.
    - iii. The majority of the prescriptions written by REDACTED are clinically reserved or recommended for acute care by CDC pain management guidelines which do

not recommend treatment with opioids for greater than six months for chronic conditions. Patients seen by REDACTED have been on opioid treatment for greater than six months.

2. REDACTED refused to comply with requests for medicals records to substantiate prescription claims paid by Medicaid in 2017 through 2020 that he prescribed.

REDACTED signed a Medical Assistance Provider Enrollment & Trading Partner Agreement on November 3, 2014. 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:

- There is a reasonable belief that the provider is refusing to comply with section 111b(7), which requires providers to make available any record required to be maintained by subsection (6) for examination and photocopying by authorized agents of the director. Subsection (6) requires providers to maintain records necessary to document fully the extent and cost of services, supplies or equipment provided to a medically indigent individual and to substantiate each claim and, in accordance with professionally accepted standards, the medical necessity, appropriateness, and quality of service

rendered for which a claim is made.

- There is 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.
- 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 31, 2021.

*Exhibit F, pages 1-2*

30. On April 9, 2021, MOAHR received the request for hearing filed by Petitioner in this matter with respect to the Order of Summary Suspension.
31. On April 14, 2021, Petitioner certified and provided records to the HCFD. (Exhibit 2, pages 1-2).

### **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:

\* \* \*

(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:

- (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, a Senior SIU Investigator at ABH-MI testified regarding an investigation she completed after being assigned Petitioner's case following ABH-MI's receipt of information from its Ohio Plan regarding a referral to the Ohio Department of Medicaid. That referral in Ohio included allegations that Petitioner was prescribed opioids and muscle relaxants to patients, including patients who travelled over an hour to see him, without there being any claims for office visits. The referral also noted that Petitioner had lost his license in Ohio and the United Kingdom for not disclosing that his license had been suspended. The Senior SIU Investigator did not seek any records for patients in Ohio as she only handles Michigan and she does not know what happened, if anything, in Ohio with respect to the referral. She did look for administrative actions involving Petitioner and confirmed his suspensions due to licensing issues.

The Senior SIU Investigator also testified that, as part of her investigation, she reviewed claims submitted and paid in Michigan and found claims paid for prescriptions written by Petitioner without any claims for corresponding office visits, which she found concerning as you need office visits to determine the appropriateness and medical necessity for medications.

She further testified that she requested, and received, older medical records from Petitioner's previous employers; she forwarded the records to a Medical Director at ABH-MI for a review; and the Medical Director reviewed the records and raised concerns about Petitioner's prescribing practices. The Senior SIU Investigator cannot speak to the concerns or their truth, and she does not know the Medical Director's specialty. She also testified that the Medical Director wrote a report, but that she did not include it in the fraud referral submitted to the OIG because the concerns were written out in the referral itself.

The Senior SIU Investigator then testified that she contacted Petitioner's office and requested more recent medical records, but that, despite Petitioner stating he would send them, the records were never sent. She also testified that, approximately thirty days later, she contacted him again and he asked that she resend the request as he had discarded it. She further testified that, after she resent the request, Petitioner indicated that he would not be sending the records in and that any further contact should be with his attorney. The Senior SIU Investigator did agree that the written request to Petitioner did not say she was requesting records on behalf of Medicaid and, instead, referred to the standard provider contract, which Petitioner had not signed as he was not a participating provider with ABH-MI. She also agreed that the written request did not say anything about suspected fraud, but further testified that she explained the grounds for her request during her conversations with Petitioner.

The Senior SIU Investigator further testified that she submitted the fraud referral to the OIG and explained why she did so. She also testified that she had spoken with Petitioner's attorney prior to doing so, who had indicated that he would have the records sent, but that she never received anything and sent the referral to the OIG prior to deadline identified in the second request for records because Petitioner has said he would not send them; the matter involved a quality-of-care issue; and she could not wait any longer.

The Section Manager with the Department's OIG testified that, as part of her job duties, she reviews fraud referrals from Medicaid Health Plans (MHPs) such as ABH-MI, with MHPs required by their contract with the State of Michigan to conduct investigations when fraud is suspected.

She also testified that she received and evaluated the referral from ABH-MI with respect to Petitioner in this case. As part of that evaluation, she confirmed Petitioner is a Medicaid enrolled provider; pulled claims to see his impact on the program; and reviewed the contents in the referral. She does not recall any documents attached to the referral or what was in the list of claims, which was not reviewed medically regardless.

She further testified that she sent the referral on to the Michigan Department of Attorney General Health Care Fraud Division (HCFD); corresponded with them; and confirmed that they were opening an investigation. She does not know the status of that investigation and usually does not hear anything until it is finished, but that the acceptance of the referral and the opening of an investigation by the HCFD suggests that a credible allegation of fraud exists.

The OIG Section Manager also testified that the OIG determined that a credible allegation of fraud against Petitioner existed, and that an order of summary suspension had to be issued, based on a number of factors. In addition to the fact that the HCFD had opened an investigation, she noted the concerns by ABH-MI's Medical Director raised about the medical records he reviewed; Petitioner's failure to submit responses to the investigation as required by law; and the existence of hundreds of paid claims without corresponding office visits with Petitioner. She did testify that there was no independent investigation by the OIG to determine the credibility of the allegations in the fraud referral or an attempt to obtain records on its own, as the investigations are left to the MHPs and the HCFD, and that the language in the order of summary suspension was pretty much taken verbatim from fraud referral. She also testified that the OIG did not have the claims or concerns raised by ABH-MI's Medicaid Director reviewed by a Medical Services Administration physician, though it could have done so.

The Section Manager also testified that Petitioner is not required to bill Medicaid for all office visits for Medicaid patients and that she does not know if Petitioner had records to substantiate the prescriptions, but that there would no longer be fraud concerns if they do exist.

In response, Petitioner testified as to his education and experience as a doctor. He also testified that he does not consider himself a Medicaid provider, as he does not accept or bill Medicaid, but that he now knows that he is still as a enrolled Medicaid provider. He further testified that he does see patients who use Medicaid for other things, like prescriptions, but the patients are also advised that Petitioner does not accept Medicaid.

Petitioner also testified that, while the Senior SIU Investigator did contact him, she never said anything about Medicaid and instead presented it as independent audit; and that Petitioner would have provided the requested records if he had known that she was acting

as an agent of Medicaid. Petitioner did agree that he initially told the Senior SIU Investigator that he would provide the requested records, but that he later changed his mind and decided to seek legal advice. He also testified that, after the order of summary suspension, he provided the records to the HCFD.

Petitioner further testified regarding the concerns identified by the ABH-MI Medical Director and how those concerns are wrong or inaccurate.

Petitioner also testified that he was surprised by the Order of Summary Suspension, and that he was never given a chance to explain or defend himself.

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.

It is undisputed in this case that, if Petitioner was indeed writing prescriptions for opioids and muscle relaxants without having examined the patients and the medications being determined to be medically necessary and appropriate, then those actions would constitute fraud under 42 CFR 455.23 and the Medicaid False Claims Act.

Allegations of such behavior exist in this case and, following an investigation conducted ABH-MI pursuant to its contract with the Department, a fraud referral was made to the Department, who properly determined that that the fraud allegations were credible and that there was a reasonable belief that Petitioner had violated the Medicaid False Claims Act.

As fully explained by the Department, those findings were based on the fraud referral findings that hundreds of claims for prescriptions for opioids and muscle relaxants had been paid by Medicaid between 2017 and 2020 without any corresponding office visit billed for Petitioner to evaluate the patients for medical necessity for those opioids or muscle relaxants; Petitioner had failed to comply with requests for medical records to substantiate prescription claims paid by Medicaid in 2017 through 2020 that he prescribed; and a review of medical records involving Petitioner from 2015 and 2016 by the ABH-MI Medical Director raised concerns about Petitioner's prescribing habits, including a lack of therapy notes and documentation regarding attempts at more conservative treatment. The Department also noted that the fraud referral 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.

In response, Petitioner takes issue with the investigation conducted by the ABH-MI and the lack of any further investigation by the OIG. For example, he testified that he had no idea that the MHP was acting on behalf of Medicaid and that he would have sent the requested records if he had, as he later did to the HCFD. He also disputes the concerns raised by the ABH-MI Medical Director and argued that further investigation into the

dispute would have demonstrated both that Petitioner was correct and that the Medical Director's concerns were incorrect or unwarranted. Petitioner further notes that the OIG could have conducted its own inquiry rather than relying on what the MHP did and taking its findings directly from the fraud referral without any corroboration or investigation.

However, while Petitioner is correct in arguing that the OIG could have conducted further investigation into the allegations forwarded to it prior to issuing the order of summary suspension, he also fails to point to any requirement for such further investigation and, as argued by the Department's representative, an extensive investigation by the OIG in this case would seem inappropriate given its contract with the MHP, the nature of the temporary suspension at issue, and the ongoing investigation by the HCFD. Moreover, Petitioner's arguments with respect to the investigation by the MHP are likewise unpersuasive given the Senior SIU Investigator's credible testimony regarding what she told Petitioner about the investigation and the undisputed circumstances of this case, which included Petitioner saying he would provide the requested records, doing nothing for approximately a month, asking that the request be resent once the investigator contacted him again, and only then saying that he would not send in the records.

The standard for suspension in this case is low, with the Department only having to establish 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 the Department met that low standard given the hundreds of claims for opioids or muscle relaxants without claims for corresponding office visits; Petitioner's failure to provide documentation to explain that discrepancy despite saying he would and being given ample opportunity to do so; the concerns raised by a Medical Director after review of older claims that ABH-MI was able to obtain; and the HCFD finding that an investigation was warranted.

For the reasons stated above and having considered both the whole record and the parties' arguments in full, the undersigned Administrative Law Judge therefore finds that 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 also finds that the summary suspension should be upheld in this case.

**IT IS THEREFORE ORDERED** that:

- The Order of Summary Suspension issued by the Department to Petitioners on March 29, 2021 is UPHELD.