SOAH DOCKET NO. 529-13-0997
HHSC-OIG CASE NO. P20111316523848911

ANTOINE DENTAL CENTER,	**§**	**BEFORE THE STATE OFFICE**
Petitioner,	**§**	
	§	
VS.	**§**	
	§	**OF**
TEXAS HEALTH AND HUMAN	**§**	
SERVICES COMMISSION,	**§**	
OFFICE OF INSPECTOR GENERAL,	**§**	
Respondent.	**§**	**ADMINISTRATIVE HEARINGS**

PETITIONER'S CLOSING ARGUMENT

TO THE HONORABLE ADMINISTRATIVE LAW JUDGES:

NOW COMES Petitioner Antoine Dental Center (hereinafter "ADC") and files this closing argument and would show as follows:

I. BACKGROUND & DISPOSITIVE QUESTIONS

A. The Texas Medicaid Program for Orthodontics

The overriding question before this court is whether, as of April 4, 2012, the OIG possessed a credible allegation upon which it could impose a payment hold, and if so, what level of payment hold is appropriate based on the credible evidence. However, there are several dispositive questions that should define the scope of this panel's review.

1. Prior Authorization Process and HLD Score Sheet

How can the OIG support any credible allegation of impropriety regarding HLD score sheets when the underlying diagnostic material was made available to the State, and the State pre-approved the analysis that was reflected on the HLD score sheets?

The State's Prior Authorization Process prevents the OIG from alleging that ADC submitted false information to meet prior authorization requirements. The Prior Authorization Process was implemented to assure that qualifying orthodontic services were supported by an accurate HLD score sheet. The State could assure the accuracy of the HLD score sheets because it required that a complete set of diagnostic material—x-rays, pictures, and cephalometric

tracings—be submitted along with the HLD score sheet.[1] Thus, the Prior Approval Process permitted the State to review all of the material that ADC used to complete HLD score sheets.

Although the OIG now claims that HLD score sheets were falsified to inflate the final HLD scores, it is noteworthy that the OIG does not question the veracity of the supporting diagnostic material. This is important because the State not only possessed accurate underlying diagnostic material that related to each HLD score sheet, but the State had also implemented a pre-approval system whose apparent purpose was to: 1) review that underlying diagnostic material, 2) confirm (or, alternatively, overrule) the objective and/or subjective accuracy of the HLD scoring against that diagnostic material, and 3) confirm (or overrule) ADC's opinion regarding the patient's dental condition. Against this backdrop, it is silly for the State to allege that ADC's submissions and its own review of those submissions could amount to fraud.

Whether the State's agent properly performed its review and pre-approval responsibilities is irrelevant. The State imposed a Prior Approval Process, and ADC operated pursuant to those pre-approval requirements. Now the State should be required to abide by both the express and implied terms of that process—namely, that it agreed with ADC's diagnosis on the HLD score sheets. The State should not be allowed to change its mind some five years later and "unapprove" the services. The State's prior approval of HLD score sheets meant something; it meant that the State approved of ADC's opinion regarding the appropriate HLD score for each patient. The OIG should not be permitted to argue that pre-approval meant nothing. This panel should find that the State's Prior Approval Process prevents the OIG from presenting a credible allegation of any impropriety, unless there is some evidence that the diagnostic material used in the Prior Approval Process was fabricated.

2. Medical Necessity

a. HLD scoring is subjective, but a qualifying, pre-approved score of 26 or more indicates a handicapping malocclusion *per se*.

The Prior Approval Process and the HLD score sheet criteria relieve this panel from any need to analyze the definition of "medical necessity" or "handicap" or "dysfunction." The process for determining whether a patient's needs were "medically necessary," or whether the patient suffered from a "handicapping" or "dysfunctional" malocclusion is not necessary when

[1] RR1, P73 Line 15 – P74 Line 3. (Citations to the Reporter's Record will be RR[Vol No.], P[age no.], and line [number]).

the patient's HLD score sheet indicated a score of 26 or higher. A score of 26 or higher indicated that the patient's condition was handicapping *per se*.[2] There has never been any indication that the HHSC intended for providers to have to independently find that a service was medically necessary or that the patient suffered from a handicapping malocclusion if the patient's HLD score sheet was 26. However, the manual did provide for the possibility that a patient who scored less than 26 could still suffer from a handicapping malocclusion. Stated differently, an HLD score of 26 meant that the patient's handicapping malocclusion was *de facto* shown, but a medical necessity for orthodontic treatment could also be present in patients that did not score at least 26 on their HLD score sheet.

b. Jurisdiction to question whether any dental service was medically necessary lies exclusively in the Board of Dental Examiners, not the OIG.

To the extent that the OIG claims that ADC breached the standard of care by providing medically unnecessary services, the OIG is generally barred from asserting standard of care violations. The jurisdiction for determining whether a dentist has violated the standard of care lies in only two places: courts of broad original jurisdiction, such as District Courts, or alternatively before the Texas Board of Dental Examiners (hereinafter "TBDE"), which has exclusive jurisdiction to regulate the industry, interpret the Dental Practice Act, and enforce its own rules against its own licensees. That argument is set out in Section II.E.(2), below.

3. Other Required Obligations

ADC agrees that the HHSC has the authority to impose certain program requirements on Medicaid providers. ADC also agrees that HHSC has the authority to take administrative action against provider that violate those express program requirements that are set out in the provider manual and that do not rely on another agency (such as the TBDE) or branch of government (such as a criminal district attorney) for adjudication.

B. Antoine Dental Center's Practice

Dr. Behzad Nazari, a dentist in practice in Houston, Texas has owned ADC since 1998. He is a general dentist[3] and a former pharmacist.[4] Since graduating from Dental School in

[2] RR3, P99 Line 23 – P102 Line 16.
[3] RR4, P.69 Line 21-22.
[4] Dr. Nazari was a licensed pharmacist from July 1991 – November 2011, License No. 32697. See http://www.tsbp.state.tx.us/dbsearch/pht_zoom.asp?id=32697

Houston he has taken over 750 continuous education hours in orthodontics and occlusions.[5] ADC's patient profile is approximately 60% to 70% Medicaid patients. The remainder of ADC's patients are private pay.[6] Dr. Nazari was trained by Dr. Jim Orr as to how to score an HLD score sheet.[7]

Dr. Wael Kanaan has been on staff with ADC since 2006.[8] His credentials are impeccable. He finished dental school at Aleppo University in 2000.[9] He did a mini-residency program 2002 at Harvard University, and finished his residency 2005 from St. Louis University. He completed a master thesis during his residency, and then did a one-year fellowship at the cleft lip and palate team at St. Louis Children Hospital. He is a specialist in orthodontics, and is further specialized within orthodontics with regard to cleft lip and palate conditions.[10]

C. **State's Investigation:**

1. **The reason for the investigation and selection of providers**

In 2008, despite a public audit that had identified what the OIG now characterizes as "a gap in the prior authorization process,"[11] the HHSC permitted Medicaid providers to rely on the prior authorization process for years. The OIG began its investigation of orthodontic providers in June 2011.[12] ADC was one of the top 25 Medicaid orthodontia providers.[13] The decision to pursue Medicaid providers like ADC was prompted in part by news stories that "heightened the urgency" to appear responsive to what some news outlets had characterized as improper.[14]

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[5] RR4, P.90 Line 14-17.
[6] RR4, P.33 Line 14-20.
[7] RR4, P137 Line 17-25.
[8] RR3, P6 Lines 8-12.
[9] RR3, P97 Line 21- p98 Line 2.
[10] RR3, P98 Lines 6-12.
[11] RR3, P196 Line 25- P197 Line 14. Testimony of Jack Stick, "…if you could succinctly tell the Administrative Law Judges how that 2008 audit spurred you to want to undertake additional investigation regarding the providers? A. So, knowing the background, knowing that in 2008 we had already identified that there was a gap in the prior authorization process, we then looked at the utilization rates, so the actual dollars that were flowing out of the Medicaid program Title XIX, into orthodontia and we saw that each year from 2008 beyond -- actually from, you know, whenever the program was initiated, even years before that, there had been a steady and increasingly obvious increase in the dollars that were expended through -- through Title XIX for orthodontic benefits."
[12] RR3, P195 Lines 14-22. Testimony of Jack Stick, "Q. When did that investigation begin, sir? A. In late June or early July of 2011 I asked that my division prepare a -- an analysis of the top utilizers of the orthodontic benefits program to determine whether or not we had an ongoing problem in the overutilization of the orthodontic program. And I was given within a couple of days a list of about 55 providers who were the highest utilizers of orthodontic services in Texas."
[13] RR3, P198 Line 3-4.
[14] RR3, P198 Line 5-17. Testimony of Jack Stick, "Q. Now, was your decision to pursue an investigation or undertake an investigation of Antoine Dental Center prompted in any way by the WFAA news story that was aired in Dallas, Texas, sometime in the fall of 2011? A. Not entirely but in part. I think the WFAA stories certainly

2. Initial Investigation and findings

On April 4, 2012 a payment hold was instituted against ADC. The current amount being held is approximately $555,779.41.[15] The time period of the audit was from November 1, 2008 to August 31, 2011 as per the Payment Hold Letter and filed Complaint.

3. Standards for Finding Actionable Program Violations and Recoupment.

There is no statutory authority to impose a payment hold for an alleged program violation. ADC disputes that the HHSC and OIG have the statutory authority to promulgate rules that expand the OIG's authority to impose a payment hold.

Nevertheless, even if the OIG has the authority to impose a payment hold for an alleged program violation, it is noteworthy that Texas Government Code § 531.102(g)(2) only permits a payment hold for willful or intentional acts (fraud is an intent crime). Consistent with that approach, it appears appropriate to require the OIG provide evidence of intent to commit the program violation. In addition to requiring evidence of intent, ADC submits that the OIG must be required to prove: 1) probable cause (a fair probability) that a program violation has occurred, 2) the ability to permanently withhold payment for such a violation, and 3) the amount of payment that can be withheld for such a violation.

ADC submits that probable cause requires reliable evidence that, given the totality of the circumstances, are sufficient to lead a prudent person to believe that ADC committed a program violation. Then the OIG must provide evidence of its ability to permanently withhold payment for such a program violation; this analysis should reference the common-sense approach of *Texas Dept. of Human Services v. Christian Care Centers, Inc.*, 826 S.W.2d 715, 721 (Tex. App.—Austin 1992, writ denied), where the Austin Court of Appeals found that the Texas Department of Human Services had no basis for withholding payments just because a nursing home failed to complete the proper forms. Finally, the OIG must provide this court with an actual value to be assigned to each category of alleged program violation; without knowing the "damage" that a program violation causes, the reasonableness of a subsequent payment hold is

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heightened -- maybe underscored the importance of these investigations. When we looked at the top 56 providers, you know, we -- as I indicated we became aware that there was ongoing -- potentially an ongoing problem and I think the WFAA stories maybe heightened the urgency of conducting the investigations."

[15] See Ex. P82, Respondent's Memorandum of Law filed 5/20/13; Subsequent additions to that aggregate amount has pushed the amount to nearly $1 million ($909,780.48 as of the filing of this closing argument).

lost. For example, if a dental mold is missing, is that worthy of a 100% recoupment for services rendered to that patient? Or on all Medicaid patients treated by the practice?

4. Revisions to the Allegations against Antoine Dental Center.

The Respondent filed a Trial Supplement to the Respondent Complaint and it was denied by the Court.[16] The attempted revisions in the Supplemental pleading is an admission of the lack of evidence in the record regarding the OIG's allegations. The payment hold was originally levied on the allegations in the original complaint, and it is appropriate for this court to require the OIG to defend its original claims. The OIG's effort to change its complaint is both an admission that it had grossly overstated its case from the beginning, and a last minute effort to make its remaining allegations look stronger then they were. After all, if this court had permitted the OIG to amend, and the OIG had been able to prevail on all of its revised claims, there is no doubt that the OIG would argue that prevailing on 100% of its claims would justify continuing a 100% payment hold against ADC.

II. APPLICABLE LAW AND LEGAL ISSUES

A. Authority to Impose Payment Holds (and the requirement to lift them)

Generally, Judge Kilgore's analysis of the authorization for payment holds in *Harlingen Family Dentistry vs. HHSC-OIG* was correct, with a few minor corrections. The Texas Legislature has been explicit about the circumstances that will justify a payment hold. The Legislature has given the OIG the power to impose a payment hold pursuant to Texas Government Code § 531.102(g)(2), and, indirectly, by reference in state law to 42 C.F.R. §§455.23 and 455.2. The OIG's authority for a payment hold provides:

> (2) In addition to other instances authorized under state or federal law, the office shall impose without prior notice a hold on payment of claims for reimbursement submitted by a provider to compel production of records, when requested by the state's Medicaid fraud control unit, or on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or wilful misrepresentation under the state Medicaid program in accordance with 42 C.F.R. Section 455.23, as applicable. The office must notify the provider of the hold on payment in accordance with 42 C.F.R. Section 455.23(b).

[16] RR1, P122.

There is no other statutory authority for the OIG to issue a payment hold against a provider.[17]

Texas Government Code § 531.102 does not address what should occur if the State fails to substantiate a case for fraud or willful misconduct. But its statutory counterpart found at Texas Human Resources Code § 32.0291 does. Section 32.0291(c) expressly states that any payment hold must be discontinued "unless the department makes a prima facie showing at the hearing that the evidence relied on by the department in imposing the hold is relevant, credible, and material to the issue of fraud or wilful misrepresentation." Thus, if the OIG fails to show credible allegation of fraud or willful misconduct, the payment hold must be lifted in its entirety.

The OIG cites rules HHSC rule 371.1703(b)(5) and (6) as authority for imposing a payment hold for a credible allegation of a program violation.[18] That rule states, in pertinent part:

> …
> The instances in which a payment hold may be imposed without prior notice are:
> …
> (5) for any reasons specified in §§371.1609, 371.1617, 371.1621 of this subchapter, or any other provisions delineated in these rules; or
> (6) for any other reason specified by statute or regulation.
> …

1 TAC 371.1703(b) (repealed as of October 14, 2012, but still in effect for alleged violations committed prior to that date. 37 Tex Reg 7990). Rule 371.1617 list over fifty general categories of program violations. These rules cannot preempt the statutory mandate in Texas Human Resources Code § 32.0291(c).

B. Authority Governing the Percentage Withheld from Provider

A prehearing deprivation of property implicates Constitutional due process protections.[19] In the abstract, common sense says that if a payment hold is appropriate, the payment hold must be set at a level that corresponds to the credible allegations, and the payment hold should never be permitted to accumulate funds to a level that exceeds the credible allegations. Stated differently, if this panel finds that a payment hold was justified on April 4, 2012, it will be necessary to determine not only what percentage of Medicaid billings should be retained going

[17] Human Resources Code § 32.0291(b) gives the HHSC, not the OIG, separate authority to impose a payment hold. It references "the department," as opposed to the Government Code's reference to "the office."
[18] ADC asserts that rule 371.1703(b)(5) and (6) are invalid rules. Those rules are currently being challenged in 419th Travis County District Court, *Harlingen Family Dentistry v. HHSC and OIG*, Cause No. D-1-GN-13-002402.
[19] *See United States v. James Daniel Good Real Prop.*, 510 U.S. 43, 51, 114 S. Ct. 492, 500, 126 L. Ed. 2d 490 (1993); *Fuentes v. Shevin*, 407 U.S. 67, 92 S.Ct. 1983, 32 L.Ed.2d 556 (1972).

forward, but also what should be done with the past accumulation of funds, and what absolute level of accumulated funds the OIG has shown itself entitled to withhold pending a final merits hearing. No orthodontic overpayment hearing has ever proceeded to a final order (indeed, there has never been a final HHSC order issued on any allegation of overpayment for any provider). It is conceivable that if the State has not already retained more funds from ADC than it has shown itself entitled to recover, it will probably do so before ADC gets a final order on the issue of overpayment.

C. Burden of Proof and Standard of Review

The OIG maintains the burden of proof. The Standard of Review is set out in Texas Government Code § 531.102(g)(2), which only discusses the imposition of a payment hold if the OIG has "reliable evidence that the circumstances giving rise to the hold on payment involve fraud or wilful misrepresentation under the state Medicaid program in accordance with 42 C.F.R. Section 455.23, as applicable."

D. Authority of Texas Medicaid Health Partnership to Bind State

It is undisputed that THMP's actions bind the state. Case law supports the position that where TMHP acts as the State's agent in making prior authorization decisions regarding Medicaid eligibility, the State has consented for all purposes, including liability for attorney fees. In *Koenning v. Suehs*, 897 F. Supp. 2d 528 (S.D. Tex. 2012), three disabled young adults alleged that they required custom power wheelchairs with integrated standing features to meet their medical, functional, and mobility needs. Wheelchairs, which are a type of durable medical equipment, require prior authorization. HHSC, acting through THMP, denied the prior authorization determination for all three individuals. The court never questioned TMHP's authority to bind HHSC. The court held that to the extent that TMHP's prior authorization denial violated the Medicaid program, the plaintiffs were not required to exhaust their administrative remedies, and were additional entitled to recover their costs and attorney fees from HHSC. The court remanded the case to TMHP to determine whether the motorized wheelchairs were medically necessary. Similar holdings have been reached in similar cases.[20]

[20] *Detgen ex rel. Detgen v. Janek*, 3:11-CV-2974-G, 2013 WL 961506 (N.D. Tex. Mar. 13, 2013) (TMHP's denial of prior authorization for durable medical equipment conferred right to a hearing, and permitted plaintiffs to subsequently sue HHSC Executive Director for violations of 42 U.S.C.A. 1983); *Jonathan C. v. Hawkins*, CIV A 9:05-CV-43, 2006 WL 3498494 (E.D. Tex. Dec. 5, 2006) (acknowledging that HHSC contracts with TMHP for the administration and prior authorization of the Medicaid benefits at issue in the case, and holding that where TMHP's prior authorization denial was improper, action against HHSC would lie).

The undersigned counsel could find no case law indicating that TMHP pre-authorization decisions were not decisions by HHSC.

E. Fraud and Willful Misrepresentation and Program Violations

1. Fraud and Willful Misrepresentation

To prove an action for common-law fraud, the OIG must establish that ADC made a false representation.[21] A false representation consists of words or other conduct that suggests to the State that a statement is true when it is not.[22] There are four types of false representations,[23] but only the first two types of statements are implicated in this case: 1) false statement of fact, and 2) false statement of opinion.

A false statement of fact is an untrue, deceptive, or misleading statement concerning a past or present fact.[24] To determine whether the statement is fact or opinion, courts consider the specificity of the statement, the parties' relative level of knowledge, and whether the statement relates to the present or future.[25]

An expression that is purely opinion is not considered a false representation.[26] To be a misrepresentation, a statement must concern fact as opposed to mere opinion, judgment, probability, or expectation.[27] The only exceptions to this rule are:

1) If the defendant knows that his statement of opinion is false,[28]
2) If the defendant's opinion is based on or intertwined with false statements of fact,[29] or

[21] *See Exxon Corp. v. Emerald Oil & Gas Co.*, 348 S.W.3d 194, 217 (Tex. 2011).
[22] *See Custom Leasing, Inc. v. Texas Bank & Trust Co.*, 516 S.W.2d 138, 142 (Tex. 1974); *State Nat'l Bank v. Farah Mfg.*, 678 S.W.2d 661, 681 (Tex.App.—El Paso 1984, writ dism'd).
[23] The four types of false representations that can substantiate fraud are: (1) false statement of fact, (2) false statement of opinion, (3) false promise of future performance, and (4) false representation of conduct.
[24] *See Farah Mfg.*, 678 S.W.2d at 681; *see e.g., Padgett v. Bert Ogden Motors, Inc.*, 869 S.W.2d 532, 535 (Tex. App.—Corpus Christi 1993, writ denied)(mechanic's statement that care was "completely repaired" and "completely fixed" was a representation of existing material fact).
[25] *Transport Ins. v. Faircloth*, 898 S.W.2d 269, 276 (Tex. 1995).
[26] *Italian Cowboy Partners v. Prudential Ins.*, 341 S.W.3d 323, 337-38 (Tex. 2011); *Transport Ins.*, 898 S.W.2d at 276; *BP Am. Prod. v. Marshall*, 288 S.W.3d 430, 443 (Tex.App.—San Antonio 2008), *rev'd on other grounds*, 342 S.W.3d 59 (Tex. 2011); *see Sheehan v. Adams*, 320 S.W.3d 890, 899-900 (Tex. App.—Dallas 2010, no pet.); *Jeffcoat v. Phillips*,, 534 S.W.2d 168, 171 (Tex.App.—Houston[14th Dist.] 1976, writ ref'd n.r.e.).
[27] *Jeffcoat*, 534 S.W.2d at 171.
[28] *Trenholm v. Ratcliff*, 646 S.W.2d 927, 930 (Tex. 1983)
[29] *Transport Ins.*, 898 S.W.2d at 277; *Trenholm*, 646 S.W.2d at 930. If the opinion is intertwined with misstatements of fact, the opinion amounts to a false representation of fact. *Trenholm*, 646 S.W.2d at 930.

3) If the opinion is based on the defendant's "special knowledge" and the defendant should have known that the plaintiff would rely on the defendant's "special knowledge."[30]

2. Program Violations

Although Rule 371.1703 (through 371.1617) permits the OIG to impose a payment hold for a program violation, the OIG may not impose a payment hold based on an allegation that a provider violated the Dental Practice Act, unless the provider has been finally sanctioned by the Texas Board of Dental Examiners (hereinafter "TBDE"). It is the TBDE, not the OIG, that has exclusive and/or primary jurisdiction over any allegation that ADC violated the Dental Practice Act. Therefore, SOAH should not consider any evidence or argument that seeks to justify an alleged "program violation" based on an allegation that ADC violated the Dental Practice Act or rules.

An administrative agency has exclusive jurisdiction when the legislature has granted the agency the sole authority to make an initial determination in a dispute.[31] An agency has exclusive jurisdiction "when a pervasive regulatory scheme indicates that [the Legislature] intended for the regulatory process to be the exclusive means of remedying the problem to which the regulation is addressed."[32] It is indisputable that the Dental Practice Act, and the regulations promulgated by the TBDE, is a pervasive regulatory framework meant to be interpreted and enforced by the TBDE. Whether or not ADC's actions constitute a violation of the Dental Practice Act is a matter entrusted solely to the TBDE. Absent a final TBDE order (or, for the sake of a payment hold hearing, any sort of formal allegation from the TBDE), the OIG has no authority to assert

[30] *Transport Ins.*, 898 S.W.2d at 277; *see Italian Cowboy*, 341 S.W.3d at 338; *Trenholm*, 646 S.W.2d at 930; *see e.g., Safety Cas. Co. v. McGee*, 127 S.W.2d 176, 179 (Tex. 1939) (adjuster with access to certain data misrepresented calculation of worker' compensation benefits to induce a settlement); *Buchanan v. Burnett*, 119 S.W.1141-1142 (Tex. 1909) (buyer who knew nothing about real estate matters relied on seller's opinion that he was conveying good title). "Special knowledge" means knowledge or information superior to that possessed by the other party and to which the other party did not have equal access. *See Paull v. Capital Res. Mgmt.*, 987 S.W.2d 214, 219 (Tex.App.—Austin 1999, pet. denied). "Special knowledge" should not be confused with special expertise. Special knowledge is knowledge of specific facts that underlie a false opinion and that can support a claim of affirmative misrepresentation. *See Trenholm*, 646 S.W.2d at 930. Superior or special expertise is knowledge that is uniquely within the domain of a particular field and is never actionable as an affirmative misrepresentation, even when coupled with an opinion that turns out to be wrong. *See Paull*, 987 S.W.2d at 219-20; *McCollum v. P/S Invs.*, 764 S.W.2d 252, 255 (Tex.App.—Dallas 1988, writ denied).

[31] *Mitz v. Texas State Bd. of Veterinary Med. Examiners*, 278 S.W.3d 17, 22 (Tex. App.—Austin 2008, pet. dism'd), *citing Cash Am. Int'l Inc. v. Bennett*, 35 S.W.3d 12, 15 (Tex.2000).

[32] *Subaru of Am., Inc. v. David McDavid Nissan, Inc.*, 84 S.W.3d 212, 221 (Tex. 2002).

that ADC has committed a program violation through an alleged violation of the Dental Practice Act.

In the alternative, even if the TBDE does not have exclusive jurisdiction, it has primary jurisdiction; thus, the OIG may not allege a program violation has occurred as a result of an alleged violation of the Dental Practice Act. The primary jurisdiction doctrine requires courts to permit an administrative agency to initially decide an issue when: (1) an agency is typically staffed with experts trained in handling the complex problems in the agency's purview, and (2) great benefit is derived from an agency's uniformly interpreting its laws, rules, and regulations, where courts and juries may reach different results under similar fact situations.[33] Although the primary jurisdiction doctrine was judicially created "to allocate power between **courts** and agencies when both have authority to make initial determinations in a dispute,"[34] the concept should be applied in the context of agency-to-agency actions as well. Allowing the OIG to usurp the TBDE's (or any other agency's) interpretive power and enforcement authority is inappropriate and dangerous.[35]

The concepts of exclusive and primary jurisdiction are important in this case because the "program violations" listed in 371.1617 are broad, and often speak to infractions of other law such as the Dental Practice Act or the TBDE regulations.[36] Without a final adjudication from a court or agency with jurisdiction to adjudicate those allegations, this SOAH court must be mindful of the jurisdictional ramifications of the OIG's claims. The OIG is not free to commandeer other law, impose its own definition of what might violate that other law, or attempt to adjudicate claims that should be properly brought before another agency. If the OIG asserts that ADC committed program violations, those violations must be directly set out in

[33] *Butnaru v. Ford Motor Co.*, 84 S.W.3d 198, 208 (Tex. 2002).
[34] *Subaru of Am., Inc. v. David McDavid Nissan, Inc.*, 84 S.W.3d 212, 221 (Tex. 2002) (emphasis added)
[35] Many troubling questions would flow from permitting OIG to interpret and enforce the TBDE Act and rules. For example: Would a recordkeeping violation finding in a Medicaid case subsequently bar ADC from challenging the same allegation in a separate administrative case that might be brought by the TBDE? Or would the TBDE be barred from bringing a similar complaint against ADC, since "the State" would have already taken action under the TBDE's Act and rules? How is the SOAH able to ascertain whether the OIG's proposed interpretation of the Dental Practice Act or TBDE rule is consistent with the TBDE's own interpretations and policies? Must SOAH defer to the HHSC or the OIG's interpretation of the Dental Practice Act or rules in a Medicaid case since SOAH is acting on behalf of HHSC?
[36] RR1, p81 line 25 – p84 line 4 (discussion and questions from ALJs regarding whether retaining molds was a program violation or a TBDE rule violation); RR2, p79 line 25 – p81 line 17 (failure to abide by the TDBE rules would be a program violation);

371.1617, and cannot be indirectly created by referencing an outside authority that the HHSC did not create and does not govern.

F. Res Judicata and Collateral Estoppel

Collateral estoppel is issue preclusion. It prevents the re-litigation of an identical issue, even in connection with a different claim or cause of action. Unlike res judicata, which can apply to any claim that the parties had an opportunity to litigate, collateral estoppel applies only when the issue was actually litigated and essential to the judgment in the previous action. Under the Restatement, a party who has actually litigated an issue should not have another chance to do so.

1. The Elements of Collateral Estoppel

Courts have stated the elements of collateral estoppel differently in different situations. Generally, collateral estoppel bars a claim only if:

> "(1) the facts sought to be litigated in the second action were fully and fairly litigated in the first action;
> (2) those facts were essential to the judgment in the first action; and
> (3) the parties were cast as adversaries in the first action."[37]

However, collateral estoppel will bind a party and those in privity with him even if the parties were not actually named as adverse parties in the first action.[38] So, "being cast as adversaries" does not require mutuality to invoke collateral estoppel, it only requires that the party against whom the plea of collateral estoppel is being asserted be a party or in privity with a party in the prior litigation.[39] Thus, it is appropriate for ADC to invoke collateral estoppel in this case to bind the OIG on the same issues of fact that were resolved by the HHSC's final order in the *Harlingen Family Dentistry* case.

When applying collateral estoppel in a criminal context, the Court of Criminal Appeals stated the elements thusly:

> (1) a "full hearing" at which the parties had an opportunity to thoroughly and fairly litigate the relevant fact issue;
> (2) the fact issue must be the same in both proceedings; and
> (3) the fact finder must have acted in a judicial capacity.[40]

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[37] *John G. and Marie Stella Kenedy Mem. Found. v. Dewhurst*, 90 S.W.3d 268, 288 (Tex. 2002); *Sysco Food Servs., Inc. v. Trapnell*, 890 S.W.2d 796, 801 (Tex. 1994)
[38] *Benson v. Wanda Petroleum Co.*, 468 S.W.2d 361, 363 (Tex. 1971)
[39] *Eagle Properties, Ltd. v. Scharbauer*, 807 S.W.2d 714, 721 (Tex. 1990).
[40] *State v. Aguilar*, 947 S.W.2d 257, 259-60 (Tex.Crim.App.1997); *Ex parte Tarver*, 725 S.W.2d 195, 199 (Tex.Crim.App. 1986).

2. Application in this case

The dispute over the definition of ectopic eruption in this case mirrors what occurred in the *Harlingen Family Dentistry* case. In both cases, the parties each spent several days arguing about:

1) whether the Provider Manual actually "defined" ectopic eruption or just provided guidance;[41]
2) whether the Manual's references to certain conditions were nonexclusive examples of those conditions;[42]
3) whether the Manual's statements regarding ectopic eruption was vague and/or subjective;[43]
4) whether there was a Medicaid vs. non-Medicaid definition of ectopic eruption,[44]
5) whether the changes to the Medicaid manual's references to ectopic eruption in 2012 represented a clarification or a retroactive substantive amendment to the definition,[45] and
6) whether the definition that governed the granting of benefits in Texas Medicaid practice prior to 2012 was more expansive than the 2012 amendment.[46]

"When an administrative agency is acting in a judicial capacity and resolves disputed issues of fact properly before it which the parties have had an adequate opportunity to litigate, the courts have not hesitated to apply res judicata to enforce repose."[47] That statement is equally applicable to Texas agencies[48] for the concepts of both res judicata and collateral estoppel.[49] Here, the panel should apply the HHSC's position on each of these points because it adopted those findings in its final order in the *Harlingen Family Dentistry* case. Analyzing this case *de novo* on these fact questions risks undermining the primary purposes for collateral estoppel, namely, judicial economy, consistency, and finality.[50] Even if this panel embarks on some

[41] Harlingen Family Dentistry PFD, Finding of Fact 25.
[42] Harlingen Family Dentistry PFD, Finding of Fact 26.
[43] Harlingen Family Dentistry PFD, Finding of Fact 27.
[44] Harlingen Family Dentistry PFD, Finding of Fact 28.
[45] Harlingen Family Dentistry PFD, Finding of Fact 32.
[46] Harlingen Family Dentistry PFD, Finding of Fact 31.
[47] *Utah Construction*, 384 U.S. at 421-22.
[48] *Ramirez v. Texas State Bd. of Medical Examiners*, 99 S.W.3d 860 (Tex.App.-Austin 2003, pet. denied) (applying both res judicata and collateral estoppel from an administrative hearing to bar a civil lawsuit seeking to enjoin the board from enforcing a rule regarding reinstatement of revoked licenses); *Cianci v. M. Till, Inc.*, 34 S.W.2d 327, 330 (Tex.App.-Eastland 2000, no writ)
[49] *State v. Aguilar*, 901 S.W.2d 740, 741 (Tex.App.- San Antonio 1995), *aff'd*, 947 S.W.2d 257 (Tex.Crim.App.1997).
[50] *See Astoria Federal Sav. and Loan Ass'n v. Solimino*, 501 U.S. 104, 111 S.Ct. 2166, 115 L.Ed.2d 96, 59 USLW 4616, 55 Fair Empl.Prac.Cas. (BNA) 1503, 56 Empl. Prac. Dec. P 40,809 (U.S.N.Y. Jun 10, 1991) (NO. 89-1895) ("Such repose is justified on the sound and obvious principle of judicial policy that a losing litigant deserves no

review of the evidence regarding definition and application of ectopic eruption, this panel should adopt the HHSC's findings of fact regarding ectopic eruption. They are, after all, the only final agency statement that HHSC has ever made about the definitions and the changes made to them over the years.

III. PARTIES' ARGUMENTS AND EVIDENCE

A. January 1, 2012 Definition of Ectopic Eruption – Change or Clarification

ADC agrees that analysis of the definition of "ectopic eruption" was correctly stated in the *Harlingen Family Dentistry vs. HHSC-OIG* administrative proposal for decision. The proposal for decision was adopted by HHSC and it stands as the only statement of HHSC policy regarding the history of that term. ADC urges this SOAH panel to adopt HHSC's prior analysis and application of "ectopic eruption," and draws this panel's attention to these points:

1) HHSC has adopted Judge Kilgore's finding that the Provider Manual furnished a definition of ectopic eruption,[51] and that the HHSC **amended** the definition effective January 1, 2012.[52] These points stand in direct contrast to the OIG's position both in the *Harlingen Family Dentistry* case and in this case, where the OIG claims that the Provider Manual did not "define" ectopic eruption, and that the HHSC's change in 2012 was some sort of "clarification," rather than a substantive amendment.[53] The OIG's argument was rejected by the HHSC in *Harlingen Family Dentistry*, and should be rejected here for the same reason.
2) HHSC adopted Judge Kilgore's finding that the Provider Manual's definition of ectopic eruption is extremely vague.[54]
3) HHSC adopted Judge Kilgore's finding that ectopic eruption is an imprecisely defined term, with little common understanding or use outside of Medicaid,

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rematch after a defeat fairly suffered, in adversarial proceedings, on an issue identical in substance to the one he subsequently seeks to raise. To hold otherwise would, as a general matter, impose unjustifiably upon those who have already shouldered their burdens, and drain the resources of an adjudicatory system with disputes resisting resolution.) *See Parklane Hosiery Co. v. Shore*, 439 U.S. 322, 326, 99 S.Ct. 645, 649, 58 L.Ed.2d 552 (1979); *Benson v. Wanda Petroleum Co.*, 468 S.W.2d 361, 363 (Tex. 1971.")

[51] Harlingen Family Dentistry PFD, page 14, 26.
[52] Harlingen Family Dentistry PFD, page 9.
[53] RR Vol. 1 P92 line 18- P93 line 9; P94 Line 20-23.
[54] Harlingen Family Dentistry PFD, page 26

and the usual interpretation in the Medicaid context is relevant and important, especially given the "knowing: and "intentional" requirements in the definition of fraud.[55]

4) HHSC adopted Judge Kilgore's finding that application of the definition of ectopic eruption unquestionably requires the exercise of subjective judgment.[56]

The significance of HHSC's adoption of the proposal for decision in *Harlingen Family Dentistry* cannot be overstated. ADC believes that HHSC's final order in *Harlingen Family Dentistry* prevents this panel from considering any different definition or interpretation of ectopic eruption, absent some showing from the OIG that HHSC has taken some formal action to change its position.

But even if this court permits the OIG to submit a story of "ectopic eruption" that is contrary to the HHSC's precedent, the OIG's position remains just as meritless today as it was in the *Harlingen Family Dentistry* case.

Is this a Retroactive application?

The Texas Constitution Art. I, §16, prohibits the application of retroactive laws, stating "No bill of attainder, ex post facto law, retroactive law, or any law impairing the obligation of contracts, shall be made." In addition, Texas Human Resources Code § 22.019 states that the department may not retroactively apply a rule, standard, guideline or policy interpretation. Yet HHSC has previously agreed that is exactly what the OIG has attempted to do in this case.[57]

The annual Texas Medicaid Provider Procedures Manual (Manual), for the years 2007-thru December 31, 2011 provides a definition of "ectopic eruption" that is the same throughout this time period.[58] The Manual defines ectopic eruption every year as:

> Ectopic Eruption: an unusual pattern of eruption, such as high label cuspids or teeth that are grossly out of the long axis of the alveolar ridge.

Beginning January 1, 2012 the Manual's definition of "ectopic eruption" was changed[59] to read as follows:

[55] Harlingen Family Dentistry PFD, page 26
[56] Harlingen Family Dentistry PFD, page 26.
[57] See Harlingen Family Dentistry PFD, Finding of Fact 25, defining and interpreting "ectopic eruption"; Finding of Fact 32, stating that the manual's definition was amended.
[58] See Exhibits P65-P68. Annual Medicaid Providers Manuals.

> Ectopic Eruption: an unusual pattern of eruption, such as high labial cuspids or teeth that have erupted in a position that is grossly out of the long axis of the alveolar ridge. Ectopic Eruption does not include teeth that are rotated or teeth that are leaning or slanted especially when the enamel-gingival junction is within the long axis of the alveolar ridge.

The OIG's claim that the "change" was only a "clarification" is meritless. There is no evidence to support that position; it is a complete fabrication by the OIG. Both the spirit of the definition and the letter of the definition were changed in January 2012, and the HHSC's own characterization of the change is dispositive. There is no other evidence for this court to rely on, other than what the Bulletins or Manual provide as definitions. There were no emails, notices to the providers or private of public presentations to the providers regarding any new or old clarification of any definition. The word "clarification" is nonexistent regarding the new post January 2012 expanded definition and it was invented to support the OIG's argument in orthodontic litigation.

When the Quarterly Medicaid Bulletin was published, it again clearly referred to a "change."[60] Although Dr. Altenhoff disagrees with the terminology used by the Bulletin, the Bulletin is the official voice of the Texas Medicaid program, not Dr. Altenhoff. In the face of overwhelming evidence to the contrary, her testimony is not credible.[61]

The OIG's motivation is obvious. It is trying to expand the definition of "ectopic eruption" by calling it a clarification so that it can avoid any argument that the application of the new definition violates retroactive constitutional prohibitions if it was to be applied for years prior to 2012. The definition was changed,[62] and this has a huge impact on the rest of the OIG's

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[59] See Medicaid Bulletin, Exhibit P78.01 at page 8 ("Benefit Changes for Texas Health Steps Orthodontic Dental Services Effective January 1, 2012").

[60] Official Texas Medicaid Bulletin May/June No. 241.

[61] RR1, P93; Testimony of Dr. Altenhoff (Q The new definition that came out regarding ectopic eruption some time in this time period, would you classify that as a change? A I would classify that as a clarification. Q And if the bulletin describes it as a change, you would disagree with the bulletin? A If that's how they described it, then I would have to disagree with it.); RR1, P89 Line 5-19 (Q Will you agree with me that the definition of ectopic eruption, at least for the years 2008 through 2011, did not change? A I would agree with that. Q If I show you -- let's look at P-65. There's a-- what I want to know is whether or not this definition he had awhile ago of ectopic eruption -- Can you go to this particular definition? Can you tell us whether or not this definition here was a constant and consistent definition of ectopic eruption from at least ending in the year 2011? A Beginning when, sir? Q Well, how about 2007. A I would -- yes, I believe that is a consistent definition within the Medicaid manual.)

[62] Milwee Deposition, P85 Lines 1-15 (Q. Well, I'm not a doctor either but, I will tell you the definition that you have here now, ectopic eruption, is a lot more added here than its record. They've added, "Ectopic eruption does not

case, especially as it relates to its experts. The OIG's experts all rely on the application of the *new* definition from 2012. The definition that applies to this case is the definition that appeared in written form in the Manuals from 2007 to 2011, not the one created by and used by the OIG's expert witnesses for this litigation.[63]

B. Failure to Maintain Records, Models, or other documentation.

The OIG's allegation reads as follows:

> A Medicaid Provider Integrity investigation revealed over one hundred and forty-five (145) instances where the Petitioner failed to maintain patient records according to the law. That list includes, but is not limited to, the following items: 1. Petitioner failed to maintain at least seventy (70) dental models for patients; 2. Petitioner failed to maintain at least sixty (60) HLD score sheets; 3. Petitioner failed to provide documentation for at least twelve (12) dates of services; 4. Petitioner provided at least five (5) billing dates of service that failed to match actual dates of services rendered; and 5. Petitioner failed to provide letters that are required to be sent to TMHP for potential extenuating conditions that may have warranted treatment.

ADC response to this allegation is short and straightforward. The OIG has presented no evidence to substantially support the allegations stated above. For the 145 instances where ADC was alleged to have maintained patient records, ADC entered into evidence each document or item that was allegedly missing, except for 3 dental molds. To the extent that the OIG made any specific allegation about a specific patient's HLD score sheet, ADC provided the corresponding HLD score sheet for all 63 patients.[64] Even Dr. Tadlock, who made reference to various missing HLD score sheets, withdrew his comments after he was shown the respective score sheets.[65]

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include teeth that are rotated or teeth that are leaning or slanted especially when the enamel junction is within the long access of the alveolar ridge." That sentence was not there before. So what I would like to know from you, why did you add that sentence? A. I don't know. I'm not a dentist. It wasn't my direction. It would have been coming out of a clinical group. Q. You don't know what the effects of that sentence is? A. No, sir.)

[63] RR1, P51 Lines 17-23, Testimony of Dr. Altenhoff (However, every two months, there was a bulletin that would be issued, and that bulletin would contain any updates to the manual that had occurred in the interim time frame. As we would prepare the manual for the subsequent year, we would take everything that was published within the bulletins and we would incorporate them into the manual so that the manual in the subsequent year would contain all the updates.)

[64] *See* Exhibit P. 64.01 thru 64.63, (Pre-Authorization requests and HLD score sheets)

[65] RR1, P227 Lines 3-8. Testimony of Dr. Tadlock (Q Would you now, sir, agree that your summary should be changed to reflect that there are no missing HLD score sheets? A I would love to. Q Will you? A Yeah.); *See* Exhibits P 64-25; P 64-44; P 64-48; P 64-51; P 64-53.

Although the OIG alleged that ADC did not record dates of service,[66] Dr. Nazari explained that the patients at issue (No. 2, 4, 5, 6, 7, and 8) did not return for their braces.[67] Therefore, it would make sense that there was no date for subsequent treatment, because the patients did not return for treatment. The OIG attempted to mislead the court by referring to a document file that allegedly did not show a subsequent treatment date, when the truth was that the document file could never have reflected a subsequent treatment date because the patients never returned. Exhibits P02, 04, 05, 06, 07 and 08 reflect that the patients did not receive braces and therefore the lack of a subsequent treatment date is accurate, appropriate and not a program violation.

With regard to the OIG's claim that ADC failed to maintain 70 dental models, ADC admits that there were three missing models; Patient numbers 1, 4, and 13 are not in the file. Dr. Nazari admitted that they remained missing.[68] The other "missing" molds were produced prior to the hearing.

Finally, the OIG appears to have completely abandoned its claims that ADC "provided at least five (5) billing dates of service that failed to match actual dates of service rendered." The OIG did not elicit any testimony about these allegations, and there is no documentary evidence to support these allegations.

C. Credible Allegations of Fraud based on MFCU investigation.

The OIG's complaint states:

[66] RR4, P47-52.

[67] RR4, P76 Line 19- P77 Line 8 (Q. Now, you were also asked a series of questions about Patients 2, 4, 5, 6, 7 and 8 regarding treatment. Do you recall that? A. Yes, sir. Q. All right. Now, could you explain – you weren't asked why those patients didn't receive treatment. Would you, please, explain why? A. Well, the patients came to the office. We examined them and then, based on our evaluation of the HLD index and the diagnosis that we made, we made the determination that, you know, they need – they qualify. That -- that was our understanding. We send it to TMHP director. He approved the cases but those eight -- seven or eight patients that you just mentioned, they never came back to receive braces.)

[68] RR4, P42 Line 20 – P43 Line 3.

> On or about March 29, 2012, the Texas Attorney General Medicaid fraud Control Unit (hereinafter "MFCU") accepted a referral from HHSC-OIG bases on continuing investigation finding of credible allegations of fraud and continues to certify that its investigation of the Petitioner is ongoing. *See, Exhibit "A"* a true and correct copy of an Investigation Certification letter from MFCU, hereto attached and herein incorporated by reference. MFCU's continuance of its investigation supports the payment hold. Therefore, the payment hold is justified here under 1 TEX. ADMIN. CODE § 371.1703(b)(3) (2005); 1 TEX. ADMIN. CODE § 371.1617(1)(A), (B),(C) and (I) (2005); TEX. GOV'T. CODE §531.102 (2011); and 42 C.F.R. 455.2 and 455.23 (2011).

However, the OIG never addressed this allegation, and certainly never provided evidence that MFCU opened an investigation. There is no evidence in the record that MFCU accepted a referral from HHSC-OIG, and there is no evidence that the MFCU has certified that any alleged investigation is continuing. The Complaint refers to some attachment "Exhibit A," but that attachment is not actually attached. It was never offered as evidence, and was never accepted as evidence. In short, the record is non-existent as to any acceptance by the MFCU.

Even the testimony of Jack Stick failed to address whether the MFCU had actually accepted any alleged referral from the OIG.[69] There was no testimony regarding any response from MFCU, or whether MFCU even received and acknowledged any "referral." There certainly was no testimony that MFCU opened a criminal investigation. Sending a letter to a different division, versus accepting a referral and acting on it, are two different matters. ADC respectfully submits that Respondent failed to present any reliable evidence of any continuing investigation by MFCU.

Even if there was evidence of a referral to MFCU, acceptance by MFCU, and an ongoing criminal investigation of ADC, the analysis of this same issue from *Harlingen Family Dentistry* is sound. Namely, while a credible allegation of fraud may support a referral to MFCU, a referral to MFCU does not, by itself, create a credible allegation of fraud that will support a payment hold. The OIG must provide evidence, separate and apart from the referral and pendency of a criminal MFCU investigation, of a credible allegation of fraud. That analysis makes sense. Just because a party is being investigated for fraud does not mean that a credible allegation to substantiate the investigation exists. Indeed, investigations of fraud are undertaken so that the

[69] RR3, P234 Line 13-18 Testimony of Jack Stick (Q. By the way, have you made a referral in this case to anybody outside of OIG? A. Yes. We did. We did refer this case for criminal prosecution. Q. To whom? A. The Texas Medicaid Fraud Control Unit.)

State can actually determine whether there is enough evidence to support a charge against a defendant.

D. False Statements or Omissions

1. Prior Authorization & HLD Scoring

ADC submits that under these facts it is impossible as a matter of law for the OIG to prove a credible allegation of fraud with regard to HLD scoring. It is undisputed that the orthodontic services at issue required pre-authorization by the State.[70] It is also undisputed that ADC received prior authorization for all orthodontic services requested from TMHP.[71] It should be undisputed that TMHP is the agent for the State.[72] TMHP was contractually obligated to properly evaluate and process the orthodontic prior authorization requests in accordance with HHSC rules and regulations pertaining to the Texas Medicaid program.

While Jack Stick clearly disapproves of TMHP's handling of HLD score sheets in 2013, it is equally clear that HHSC was satisfied with TMHP's review of the HLD pre-approval process in 2007 through 2011. The evidence of this is compelling: In 2007 an audit was performed revealing the actual HLD score sheet review process by TMHP.[73] Apparently, some people thought that the HLD pre-approval process could be more thorough. But no changes were made to the pre-approval process. No changes were made to the definitions of ectopic eruption. No bulletin was released to providers indicating that a different, or more conservative, approach to HLD scoring should be considered. No one told Dr. Orr to revise his review criteria for HLD score sheets. In the face of questions regarding orthodontic utilization, the state chose to do nothing for five years. That is a tacit endorsement of the pre-approval process from 2007 through 2011.

Now, in 2013, the OIG has chosen an audacious and incredibly hypocritical position. In this hearing it attempted to show that ADC "knew"[74] that the HLD score sheets were not being

[70] 25 TAC § 33.71; *See also* TMHP Manuals re Mandatory Prior Authorization for Orthodontia; Exhibit P65 at 19.18 Orthodontic Services; Exhibit P66 at 19.19.1 Orthodontic Services; Exhibit P67 at 5.3.24.1 Orthodontic Services; Exhibit P68 at 4.2.24.1 Orthodontic Services; Exhibit P69 at 4.2.24.1 Orthodontic Services.
[71] *See* Exhibits P64-01 thru 64-63.
[72] Billy Milwee Deposition, *Pg. 16*
[73] Exhibit P-70-06 ; Texas Audit of TMHP.
[74] RR4 P141 Line 25 – P142 Line12 Testimony of Dr. Nazari by Moriarty (Do you really deny under oath that you had no knowledge that THNP had opened the door and that anybody that submitted a form that had 26 on it was going to get approved essentially? A. Yes. I never knew that. I had no idea what was going on in the background.

"properly reviewed," and somehow ADC took advantage of a "broken system." One fact is certain: It was HHSC that knew what the pre-approval process was checking, and what it was not checking. It is a bold move for the OIG to claim that the State was defrauded when it is the HHSC, and not the providers, who created the system, controlled the system, knew the systems' strengths and weaknesses, and approved the continued operation of the system (with all of the applicable definitions and reviews) for five years without an internal word of discontent.

Here is a more logical and plausible theory: From 2007 through 2011, the orthodontic pre-approval process operated exactly as HHSC wanted it to operate. HHSC put a pre-authorization process into place, and TMHP had experts like Dr. Felkner train dentists like Dr. Nazari on how to score HLD. Orthodontic utilization rose, not because providers were engaging in fraud, but because the definitions and the HLD scoring sheets were set at a level that made many Medicaid patients eligible for braces. Even as State funds flowed to the orthodontic program, and some questions were raised about the expenditure of funds, HHSC refused to change the qualifying criteria, the scoring methodology, or the applicable definitions. The OIG is free to fabricate a narrative wherein TMHP failed to do its job, but it appears much more likely that TMHP did exactly the job that HHSC told it to do. HHSC knew the criticisms of the TMHP orthodontic pre-approval process as early as 2008[75]; HHSC either disagreed with those criticisms or for some other reason chose to ignore them. If HHSC believed that there was legitimate problem with the pre-approval process prior to 2012, HHSC would have changed it. This is not just a theory, it is the truth.

It is wrong for the OIG to claim that ADC engaged in fraud. ADC did everything right. It worked within the system that HHSC ratified, and it relied on the States pre-approval (through TMHP). The system simply made many Medicaid recipients eligible for braces. ADC cannot be penalized for providing orthodontic services to patients who were qualified under the HLD criteria, and pre-approved by TMHP.

2. HLD Scoring

The OIG's attempt to prove fraud regarding HLD scoring is a more difficult task than it appears at first blush. Which definition of ectopic eruption should apply? The difference between the HLD scoring of Dr. Tadlock, the Antoine providers and Dr. Orr was the scoring for ectopic

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Q. Never had -- no orthodontist ever talked to you about that? A. No, never. Q. Came as a complete surprise to you when you first learned of it? A. Yes, definitely.)

[75] Exhibit P-70-06; August 29, 2008 Texas HHSC/Office of Inspector General Performance Audit

eruption. Dr. Orr,[76] Dr. Nazari,[77] Dr. Kanaan[78] and even Dr. Altenhoff[79] agreed that the HLD scoring for ectopic eruption involved "subjectivity." Meanwhile, Dr. Tadlock departed from the applicable Medicaid Provider Manual entirely,[80] insisting that the Manual's definition was somewhat subjective,[81] but that one could go outside the Manual for an applicable definition.[82]

Dr. Kanaan's testimony regarding the definition of ectopic eruption should be reviewed by this panel. His testimony pointed out the differences between the definition of ectopic eruption in text books[83] versus the Medicaid definition.[84] The phrase "unusual pattern of eruption" is exclusive to the Medicaid manual definition.[85] Proffit's text book focused on posterior teeth, while the Medicaid manual was limited to anterior teeth.[86] The definition in the Medicaid Manual conflicts with the definition in textbooks in important ways, and as Dr. Kanaan showed, the HHSC's modification of the definition made a bad situation worse. It is reasonable

[76] RR2, P84 Line 11-14, Testimony of Dr. Orr (Q All right. Let's see if we can break ectopic eruption down. What does ectopic mean? A Ectopic could mean several things to different people with a subjective interpretation. Out of place.); RR2, P181 Line 20 – P182 Line 2 (Q So if I understand you correctly, I think it all pretty much boils down to this definition of ectopic eruption; is that correct? A Well, of the nine criteria, several are rather objective because they measure with a millimeter rule, the differences in the teeth position. And then several have more subjectivity to them. And of course, when you get in to the ectopic eruption, it's extremely subjective.)

[77] RR4, P121 Line 8, Testimony of Dr. Nazari (Q. In other words, did you follow -- did you follow it? A. Yeah, I followed. I mean, some of the things in my professional opinion when it comes to the HLD index, I used my subjective judgment, my personal opinion.)

[78] RR3, P170 Line 1-11, Testimony of Dr. Kanaan (Q. Have you had a chance to examine the scores of Dr. Evans and Dr. Tadlock? A. I did not look into the individual ones but I look into the total ones. I can see that like on this patient Dr. Evans gave 8. Here we have 19. 11 point different for Patient Number 7. You have here 16 point difference between D. Tadlock and Dr. Evans. 16 points difference on Patient Number 19, which will -- which will show a different -- differently how subjective the issue is. Evans, zero; Tadlock, 16.)

[79] RR1, P112 Line 2-10, Testimony of Dr. Altenhoff (Q Well, more than that, the question for you, Madame, is whether or not is the HLD scoring definition of ectopic eruption for the year in question we are talking about, is that -- is that definition subject to a subjective interpretation? A It is subject to the individual's opinion. Q That being subjective, right? I can't hear you. Is that a yes? A Yes.)

[80] Along with outside authority, Dr. Tadlock applied the new 2012 definition, not the definition in effect from 2007-2011. Testimony of Dr. Tadlock, RR1 Page 188 Line 24 – Page 189 line 6. (Q You -- in forming your opinion, you rely upon definitions regarding ectopic eruption that are found outside of the provider manual, correct? A As a doctor, we are responsible for those. We learn those, we were taught those. JUDGE SEITZMAN: You just need to answer the question. A Yes, I did absolutely.)

[81] RR1, P206 Line 15-23, Testimony of Dr. Tadlock (Q The mere fact that two orthodontists come up with different measurements or scores in this HLD score sheet, you would agree that that does not mean that they have misrepresented something willfully or they have done something wrong, right? A Yes, you are correct. Q Because there's a subjective nature to this, right? A To some of this, yes.)

[82] ADC wonders whether the OIG would support Dr. Tadlock's adventure into "other authority" if ADC's dentists had also looked outside the Manual for guidance. The OIG's position in this case has consistently been that the Manual is the sole authority for Medicaid providers if the matter is discussed in the Manual.

[83] RR3, P14 Line 13-25, Testimony of Dr. Kanaan, reading the definition from the Proffit text.

[84] RR3, P15 Line 25 – P16 Line 8, Testimony of Dr. Kanaan, reciting the Medicaid definition..

[85] RR3, P111 Lines 11-22, Testimony of Dr. Kanaan..

[86] RR3, P114 Lines 14-20, Testimony of Dr. Kanaan.

to expect a discrepancy in HLD scoring given the inherent subjectivity of the Medicaid definition and the HLD scoring process.[87]

ADC respectfully submits that the OIG's evidence presented to this Court demonstrated a difference of opinion as to the definition of ectopic eruption, and therefore, a difference of opinion as to how HLD score sheets should be graded. With subjective criteria for grading HLD, the ultimate HLD score necessarily reflects the subjective opinions of the examining dentist. Under these facts, it is impossible for the OIG to prove a credible allegation of fraud because the OIG cannot prove the first element of fraud—namely a false statement of fact. An HLD score sheet is a professional opinion of an examining dentist. As stated in section **II.E.1.** above, an expression that is an opinion cannot be considered a false representation.[88] "Pure expressions of opinion are not representations of material fact, and thus cannot provide a basis for a fraud claim."[89]

To be a misrepresentation, a statement must concern fact as opposed to mere opinion, judgment, probability, or expectation.[90] The only exceptions to this rule are:

1) If the defendant knows that his statement of opinion is false,[91]
2) If the defendant's opinion is based on or intertwined with false statements of fact,[92] or
3) If the opinion is based on the defendant's "special knowledge" and the defendant should have known that the plaintiff would rely on the defendant's "special knowledge."[93]

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[87] *See* Harlingen Family Dentistry PFD at 12."The crux of the dispute is the appropriateness of the HLD scoring performed by ....orthodontic providers."

[88] *Italian Cowboy Partners v. Prudential Ins.*, 341 S.W.3d 323, 337-38 (Tex. 2011); *Transport Ins.*, 898 S.W.2d at 276; *BP Am. Prod. v. Marshall*, 288 S.W.3d 430, 443 (Tex.App.—San Antonio 2008), *rev'd on other grounds*, 342 S.W.3d 59 (Tex. 2011); *see Sheehan v. Adams*, 320 S.W.3d 890, 899-900 (Tex. App.—Dallas 2010, no pet.); *Jeffcoat v. Phillips*,, 534 S.W.2d 168, 171 (Tex.App.—Houston[14th Dist.] 1976, writ ref'd n.r.e.).

[89] *Id.* citing *Prudential Ins. Co. of Am. v. Jefferson Assocs., Ltd.*, 896 S.W.2d 156, 163 (Tex.1995).

[90] *Jeffcoat*, 534 S.W.2d at 171.

[91] *Trenholm v. Ratcliff*, 646 S.W.2d 927, 930 (Tex. 1983)

[92] *Transport Ins.*, 898 S.W.2d at 277; *Trenholm*, 646 S.W.2d at 930. If the opinion is intertwined with misstatements of fact, the opinion amounts to a false representation of fact. *Trenholm*, 646 S.W.2d at 930.

[93] *Transport Ins.*, 898 S.W.2d at 277; *see Italian Cowboy*, 341 S.W.3d at 338; *Trenholm*, 646 S.W.2d at 930; *see e.g., Safety Cas. Co. v. McGee*, 127 S.W.2d 176, 179 (Tex. 1939) (adjuster with access to certain data misrepresented calculation of worker' compensation benefits to induce a settlement); *Buchanan v. Burnett*, 119 S.W.1141-1142 (Tex. 1909) (buyer who knew nothing about real estate matters relied on seller's opinion that he was conveying good title). "Special knowledge" means knowledge or information superior to that possessed by the other party and to which the other party did not have equal access. *See Paull v. Capital Res. Mgmt.*, 987 S.W.2d 214, 219 (Tex.App.—Austin 1999, pet. denied). "Special knowledge" should not be confused with special expertise. Special knowledge is knowledge of specific facts that underlie a false opinion and that can support a claim of affirmative misrepresentation. *See Trenholm*, 646 S.W.2d at 930. Superior or special expertise is knowledge that is uniquely

None of the exceptions above can apply in this case. The first exception is not applicable because there is no evidence that ADC and its dentists even believed that their statements of opinion on the HLD score sheets were false. In fact, Dr. Nazari went to great lengths to explain his rationale for reaching each HLD score. He discussed crowding, ectopic eruption, and elucidated on his thought process for each patient that received a qualifying HLD score. In fact, all of the experts did the same, yet they all reached different conclusions. The difference in opinion between all HLD scoring experts should be evidence that, often, there was no "right" answer regarding the proper HLD score for any particular patient. And if there is no "right" answer, then it is impossible to prove that ADC's dentists knew that their opinion was wrong.

The second exception does not apply because the HLD scores are not intertwined with a false statement of fact. As stated above, the OIG does not dispute the authenticity and veracity of the underlying x-rays and pictures. Those are the sole "statements of fact" upon which the HLD scores were based. Since the true facts were known to both the State and ADC, ADC's HLD score sheets could not have been a false statement of opinion. Everyone had access to the same factual information, and the truth of that information is undisputed. Thus, the HLD score sheets were pure opinion.

Finally, the third exception cannot apply here because there is no evidence that ADC dentists had any type of "special knowledge" that HHSC and TMHP were lacking. The state knew everything that ADC's dentists knew; everyone relied on the same photos, x-rays and drawings to determine that ADC's patients qualified for braces.

It seems obvious to state that an HLD score sheet is simply an opinion rendered by dental professional. Medical opinions are, by their nature, subject to the subjective analysis of the professional. While a medical opinion can be wrong, it cannot ever be fraudulent unless the facts apply to one of the exceptions above. As a result, the OIG's fraud claims regarding HLD score sheets must fail as a matter of law.

E. Payment for Services and Items Not Reimbursable

1. Underage patients

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within the domain of a particular field and is never actionable as an affirmative misrepresentation, even when coupled with an opinion that turns out to be wrong. *See Paull*, 987 S.W.2d at 219-20; *McCollum v. P/S Invs.*, 764 S.W.2d 252, 255 (Tex.App.—Dallas 1988, writ denied).

The OIG's complaint alleges as follows:

> **Petitioner received payment for services and items which are not reimbursable.**
>
> On or about November 1, 2008 through August 31, 2011, the Petitioner billed or caused claims to be submitted for services or items that are not reimbursable. The investigation reveled that Petitioner put braces on approximately seventy (70) patients under the age of twelve years old, whom still had baby teeth, which is a program compliance error. Additionally, the Provider submitted prior authorization forms misrepresenting the severity of patients' dental condition and was paid by Texas Medicaid for services for that are not reimbursable. The above act(s) or omission(s) constitute a violation of 1 Tex. Admin. Code § 371.1703(b)(5) and (6) (2005); and 1 Tex. Admin. Code § 371.1617(1)(K), (5)(A) and (G) (2005).

The only evidence regarding this allegation was elicited from Dr. Nazari regarding patients 15, 56, and 60.[94] In that questioning, the OIG attempted to paint the treatment of children under 12 as a strict violation. The OIG's position is incorrect on the law. The Manual[95] expressly states that services may be provided to any child with a special medical necessity.[96]

Dr. Nazari explained his treatment of those children was appropriate because the patients exhibited mixed dentition.[97] Although the patients were under 12, the patients qualified for

[94] RR4, P61 Line 14-18 (Q. And have I correctly asserted to the Court that on Patient 15, Patient 56 and Patient 60, all three of those children were under 12 when you treated them? A. Yes, sir.)

[95] Exhibit P 66 at 19.19 Orthodontic Services (THSteps) for year 2008; Exhibit P 67 at 5.3.24.1 Orthodontic Services (THSteps) for year 2009; Exhibit P 68 at 4.2.21.1 Orthodontic Services (THSteps) for year 2010; Exhibit P 78: Texas Medicaid Bulletin No. 212 ("Comprehensive orthodontic services (procedure code D8080) are restricted to clients who are 12 years of age and older or clients who have exfoliated all primary dentition.); Exhibit P 79: Texas Medicaid Bulletin July/August 2008 Vol. 216 Effective September 1, 2008 (Inserting new certification of exfoliation for Prior Authorization form.)

[96] Exhibit P 66 at §19.19 "Orthodontic Services (THSteps) Orthodontic services are limited to the treatment of children 12 years of age or older with severe handicapping malocclusion, children birth through 20 years of age with cleft palate, or other special medically necessary circumstances as outlined in Benefits and Limitations below. Mixed Dentition: Children under 12 do not have to meet the HLD Score of 26 as per Exception: Cases of mixed dentition when the treatment plan includes extractions of remaining primary teeth or cleft palate. " *See also* Exhibit P 66 at page 19-39 and P Ex 80.

[97] RR4, P75 Line 21- P76 Line 18; Testimony of Dr. Nazari (Q. Does it have -- does it -- excuse me. Does it have an impact on the -- on the re- -- on the age requirement for Medicaid treatment, that meaning mixed dentition? A. No, it doesn't have an impact. JUDGE EGAN: I'm sorry. THE WITNESS: No, it doesn't have an impact. Q. (BY MR. HECTOR CANALES) Okay. If you have -- is it -- is it true, sir, that if you have mixed dentition that that is a part of the qualifying -- qualifications determination that -- that you make? A. Yes, sir. Q. All right. And is mixed dentition part of your -- the basis for your opinions that Patients 56 and 60 qualify? A. Yes, sir. Q. All right. And you stand by that -- stand by that today towards to Patients 56 and 60? A. Yes, sir. Q. Okay. And Patient 15, was that also a case of mixed dentition? A. Yes, sir, it was a case of mixed dentition.)

Medicaid orthodontic services under all of the applicable Manual and bulletins in effect. With regard to Patient 15, the dental condition was so bad that even Dr. Tadlock approved the case.[98]

2. Patients Who did not Qualify

All patients qualified for Medicaid Orthodontic services. Save and except for the HLD scoring allegation on the definition of ectopic eruption, all patients qualified and there is no allegation that any patient was not eligible for the services.

F. Level of Payment Hold

a. Appropriateness of the 100 Percent Payment Hold

The OIG levied the payment hold for the purpose of accumulating funds in anticipation of a final overpayment hearing order in its favor. However, at the payment hold hearing the OIG has failed to provide any credible evidence to support its claim that it may be entitled to the $555,779.41 that has already accumulated.[99] In short, even if this panel finds that the OIG proved a credible allegation of something that would permit a payment hold to be imposed, this forum has no evidence upon which it may extrapolate a credible allegation to apply to ADC's total patient load. Without evidence of proper statistical sampling, extrapolation methods, and extrapolation results, it is impossible for this SOAH panel to reasonably establish the full extent of any fraud or program violations. As a result it is impossible to reasonably ascertain what level of payment hold is appropriate, or indeed, whether the $555,779.41 that has already been withheld from ADC is a satisfactory representation of what the OIG has proven a facial ability to recover.[100]

The hearing record provides no testimony regarding extrapolation, and certainly not on the extrapolation of violations from the OIG's sample to all of ADC's patients. In fact, the transcript only mentions extrapolation in passing. Although he admitted that he is not a statistician or auditor, and he did not gather, manipulate, calculate or check the OIG's conclusions, Jack Stick talked in broad terms about what he believed was involved in how the OIG investigation unit selects a provider's patient files to review. He did not discuss the method used to extrapolate the OIG's findings, and he did not discuss how the sample size could or

[98] Exhibit R-11-15.
[99] Actually, the amount held has ballooned to $909,780.48 as of the filing of this closing argument.

[100] *Id.* The actual amount is over $909,780.48, but the OIG has admitted to at least $555,000 being accumulated.

should be applied to ADC's Medicaid billings during the November 2008- August 31, 2011 time period at issue. So even if the OIG could prove a violation to support a payment hold, the OIG's failure to provide any evidence to support either the level of payment hold (percentage) or the total amount of funds sought to be withheld (total alleged overpayment) is a fundamental problem that undermines the OIG's ability to support any payment hold.

Moreover, the evidence shows that the OIG's statistical sampling, and its conclusions, are just plain wrong. Jack Stick testified that the OIG "identified 100 percent error rate" in ADC's patient files.[101] But we know from the pleadings that it not true—the OIG's live pleadings allege "over one hundred and forty-five (145) instances" of violations, and "that Petitioner put braces on approximately seventy (70) patients under the age of twelve years old…which is a program error." Those are the allegations before this panel. Apparently those allegations are the errors that the OIG identified as part of its 100% error rate that it believed justified a payment hold against ADC in April 2012. But the day before the merits hearing began, the OIG attempted to amend its pleadings to allege less than 20 instances of violations, and "approximately five (5) patients" had received braces.[102] That means the OIG's so-called 100% error-rate was wildly incorrect at the time it instituted its payment hold on ADC.

Stated differently, Jack Stick testified that there was a 100% error rate that ran through the initial 63 patient case files that the OIG reviewed; that error rate supposedly justified the 100% payment hold against ADC. However, just prior to the merits hearing the OIG changed its tune and claimed that there were only 20 violations (instead of 145) across the 63 files, with 5 patients (instead of 70) improperly receiving braces. Not only was the OIG's statistical sampling grossly inflated, those statistics, which were testified to by Jack Stick with an air of complete confidence and unassailable certainty, were the basis for the payment hold. But the OIG was wrong, overstating the alleged problem by unbelievable multiples. Clearly, the OIG's statistical sampling methodology is incorrect, unreliable, broken, and completely inconsistent as it relates to the justification for imposing the payment hold.

Furthermore, even if the OIG statistical sampling was credible, the OIG provided no evidence to support extrapolating its alleged errors onto the remaining bulk of ADC's patients. Thus, there is no evidence upon which this panel can conclude that the alleged violations are

[101] RR3. Page 231, line 5-11.

[102] See OIG's Trial Supplement to Respondent's Complaint, which was rejected by this court. Nevertheless, the pleading remains on file and is an admission as to the state of the evidence going into the hearing.

representative of ADC's patient files as a whole. To the extent that this panel might conclude that the OIG has proven a prime facie program violation in a patient file, the court's analysis must end there—it would be improper to attempt to project that error onto the remainder of ADC's files. Simply put, proof of one or more program violations is just that: proof of violations in those particular files. A violation in a single file is not proof of widespread errors or systemic violations. The OIG presented no evidence upon which this panel could conclude that an error in a patient file should somehow be extrapolated to represent an error in any other case.

Even if the OIG could have shown that an error in a single file should properly be projected onto ADC's other patient files at a given percentage rate, the OIG was required to show that it has not yet accumulated funds sufficient to satisfy any alleged overpayment on its credible allegations. The OIG failed to provide any evidence to show what amount of money had been allegedly overpaid to ADC, and it failed to provide evidence regarding how much was allegedly overpaid on each violation. Without any evidence that ADC allegedly still owes the OIG funds for an overpayment, it is unfair (and perhaps even unconstitutional) to permit the OIG to impose a payment hold at any percentage level. The OIG has already withheld over $500,000 from ADC under this payment hold, and those funds may be enough to satisfy the alleged overpayment to ADC on one or all of its credible claims (assuming there are any credible claims).

It was also necessary to show what level of alleged overpayment corresponds to each alleged violation. If, for example, this court found that the OIG had a credible claim regarding one type of program violation, but not any another, and then the court decided that the OIG's statistical sampling model was credible, and then decided to engage in its own type of extrapolation to determine how that error should be projected onto the rest of ADC's patients, it would still be impossible for this panel to determine what payment hold level is appropriate because:

1) There is no evidence of what the total overpayment amount is alleged to be for each given violation,
2) There is no evidence that the amount of funds withheld to date is insufficient to satisfy that credible allegation pending a final overpayment hearing,

3) There is no evidence that a payment hold at any level will be sufficient to recover, but not over-accumulate, funds that are alleged to have been overpaid on each given violation pending a final overpayment hearing.[103]

In short, it appears that the OIG has simply levied a payment hold on ADC without any evidence as to what ultimate accumulated fund level might satisfy their credible allegations. Further, they imposed the payment hold at a Draconian 100% payment hold level, which is practically assured to drive a Medicaid provider out of business when that business is heavily dedicated to serving Medicaid eligible patients. As a result, there is no evidence to support the continued imposition of a payment hold.

b. Payment Hold for Allegations of Program Violations:

ADC reiterates its defense that the OIG has no jurisdiction to allege that missing models, which the OIG claims to be a violation of either the Dental Practice Act or rules, can be considered program violations unless or until there is a final TBDE order. Even if this panel believes that the OIG could make such a claim, ADC reiterates that there is no credible evidence upon which three program violations could be extrapolated to create a reasonably accurate estimation of how many models might be misplaced throughout the universe of ADC patients.

ADC concedes that there are three missing models (molds). This is an insignificant and miniscule violation. The missing models did not affect the diagnosis of the patient, the quality of care, and do not affect the ability of a provider to receive reimbursement for services rendered. Therefore, this panel should find that even if it is a program violation, the program violation does not justify a payment hold in advance of an overpayment hearing. In the alternative, even if the missing models would permit the OIG to withhold, the OIG should only be permitted to withhold a nominal value for each model. It should be undisputed that the OIG has already accumulated funds from ADC that would far surpass the penalty for a missing dental model.

c. Payment Hold for Allegations of Fraud

There should be no payment hold levied for any allegations of fraud because the OIG has failed to produce credible evidence to support an allegation of fraud.

4. Resolution of funds accumulated during pendency of this payment hold

[103] Considering that there has never been a final overpayment hearing held in the history of the OIG, it is reasonable to conclude that barring some settlement of this case the OIG will eventually withhold more funds than it has a right to finally recover, even at a reduced payment hold percentage. In fact, that may have already occurred.

If this panel finds that the OIG's payment hold is not supported by a credible allegation of fraud, then the proposal for decision should address the release of fund already withheld by the OIG. Certainly, if this panel concludes that there is no credible allegation of fraud or program violation, then the panel should include a finding of fact indicating that the OIG does not now have, and never had, a credible allegation upon which to base a payment hold. In that case, the proposal for decision should require the OIG to release all withheld funds.

But this panel should consider the fate of previously withheld funds even if it finds that the OIG has a credible allegation upon which to impose some level of payment hold.[104] If this panel finds that the OIG should impose a payment hold at a level below 100%, then it should also consider the fact that any funds accumulated by the OIG were gathered under the assumption that a 100% payment hold was appropriate. Therefore, if this panel recommends that the OIG reduce its payment hold, then this panel should also recommend that the OIG return funds that were improperly withheld in the first place. ADC is entitled to credit for the funds that have accumulated during the pendency of this hearing.[105]

CONCLUSION

One year, 5 months, and 20 days ago the OIG levied a 100% payment hold against ADC, alleging fraud and making grand claims that ADC was committing hundreds of serious program violations that imperiled the solvency of the Texas Medicaid program. When the OIG was forced to simply present its claims in a "show cause" hearing, the evidence proved, at best, no fraud and only a single type of program violation; namely, misplaced models for three patients whose quality of care is not questioned. Worse, it appears that the OIG has concocted and publicly spewed a totally unbelievable lie: providers like ADC supposedly bilked an unknowing State agency and its inept agent TMHP out of millions of dollars by putting braces on unqualified children. The truth is exactly the opposite. It is the State of Texas, not the providers, that governed every aspect of the orthodontic program and the pre-authorization process. HHSC told TMHP what to do, and TMHP did exactly what they were told to do. Anything else is an after-the-fact creation by an agency looking for a scapegoat.

[104] The *Harlingen Family Dentistry* final order did not address previously withheld funds. Because the final order was silent on that issue, that final order has generated subsequent litigation in Travis County District Court regarding the OIG's duty to release funds after the final order was issued stating that the 100% payment hold was not justified.

[105] Whether the accumulated funds are $555,000 or $909,000, this panel should address their disposition.

Meanwhile, the OIG has continued to rely on those original claims to withhold over $555,000 from ADC. A 100% payment hold remains against ADC. We ask that the payment hold be lifted in its entirety, and that the OIG be ordered to disgorge all funds to which it is not entitled that have accumulated under the payment hold.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing ***Petitioner's Closing Argument*** was served via facsimile and certified mail, return receipt requested on this 23rd day of August, 2013 to the following:

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