

**APPEALS DIVISION
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
AUSTIN, TEXAS**

**ANTOINE DENTAL CARE,
Petitioner**

VS.

**TEXAS HEALTH AND HUMAN
SERVICES COMMISSION,
OFFICE OF INSPECTOR GENERAL
Respondent**

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CAUSE NO. 13-0039-K

FINAL ORDER

Antoine Dental Center (ADC) appealed the decision of the Texas Health and Human Services Commission (Commission), Office of Inspector General (HHSC-OIG), to place a 100% payment hold on all future Medicaid claims submitted by ADC. The appeal was conducted as a contested case by the State Office of Administrative Hearings (SOAH).¹ The case was assigned to Administrative Law Judge Howard S. Seitzman and Administrative Law Judge Catherine C. Egan, who conducted an adversarial hearing on May 28-31, 2013.

The HHSC-OIG payment hold is based partly on HHSC-OIG's allegation that ADC engaged in fraud and willful misrepresentation in the information submitted to Medicaid for reimbursement of orthodontics services provided to eligible Medicaid clients. HHSC-OIG alleged that ADC committed fraud by inflating the severity of its patients' dental conditions. HHSC-OIG also alleged that ADC committed non-fraudulent program violations by (1) seeking reimbursement for services excluded from coverage; (2) failing to maintain for five years documentation the provider is required to maintain or failing to provide documentation to OIG on written request; and (3) failing to comply with the terms of the Medicaid provider agreement (the Agreement), provider policy, or program procedure manuals.

Prior to the commencement of the hearing on the merits at SOAH, ADC requested that HHSC-OIG be bound by certain of the Commission's findings in *Harlingen Family Dentistry v.*

Texas Health and Human Services Commission, Office of Inspector General, SOAH Docket No. 529-12-3180 (Harlingen) based upon the doctrines of res judicata and collateral estoppel. The SOAH ALJs denied ADC's motion. The SOAH ALJs found no basis for applying either doctrine in this case.

Testifying in person at SOAH were HHSC-OIG's witnesses Linda J. M. Altenhoff, D.D.S., a dental policy expert employed by the Department of State Health Services; Larry Tadlock, D.D.S., an orthodontist who serves as an Associate Clinical Professor at the Baylor College of Dentistry (Baylor); and Jack Stick, the Deputy Inspector General for Enforcement at HHSC-OIG. Testifying in person for ADC were Wael Kanaan, D.D.S., an orthodontist who practiced at ADC; Behzad Nazari, D.D.S., the owner of ADC; and James W. Orr, D.D.S., an expert for ADC. Testifying by deposition were Irwin K. Ornish, D.D.S., an expert for ADC; and Billy Ray Millwee, the Commission's Deputy Executive Commissioner for the Health Services Operations. HHSC-OIG's orthodontic expert, Charles Evans, D.D.S., was not called as a witness, but his report was admitted into evidence.

BACKGROUND

A. The Texas Medicaid Program for Orthodontics

The Health and Human Services Commission is the state agency charged with the responsibility to administer the Texas Medicaid program.² The Commission administers the Texas Medicaid program by contracting with healthcare providers, claims administrators, and other contractors. During the times in question in this case, Texas Medicaid & Healthcare Partnership (TMHP) was the contracted Texas Medicaid claims administrator.³

In 2008 through 2011, if a provider wanted to become a Texas Medicaid Dental Provider, the provider had to complete the Medicaid "Dental Provider Enrollment Application." If the provider satisfied the eligibility requirements, the provider was allowed to provide dental services to Medicaid recipients. As part of the enrollment process, a provider agreed to comply

¹ Tex. Gov't Code Ann. § 531.102(g).

² Tex. Gov't Code Ann. § 531.021; Tex. Hum. Res. Code Ann. § 32.021.

³ Texas Medicaid & Healthcare Partnership (TMHP) is a group of private corporations and businesses led by ACS State Healthcare, LLC, which is wholly owned by Xerox Corporation and serves as HHSC's prime contractor for delivery of Medicaid claims administrator and related services. The other corporate and business members of the

with the terms of the annual Texas Medicaid Provider Procedures Manual (Manual) and the bulletin updates issued every two months. A provider also agreed that all information submitted with claims would be true, complete, and accurate and would be verifiable “by reference to source documentation maintained by Provider in accordance with the Manual.”

Dr. Altenhoff testified that the orthodontic program corrects only “severe handicapping malocclusions,” a “touch of teeth that is so inaccurate that it prevents the child from being able to chew or bite normally.”⁴ Medicaid does not cover orthodontic services that are provided solely for cosmetic reasons.⁵ In general, orthodontic benefits were further limited to the treatment of children 12 years of age or older with severe handicapping malocclusion.⁶

At all times in issue, a dental provider was required to obtain prior authorization from TMHP to be reimbursed for orthodontic care.⁷ TMHP was responsible for reviewing the filed material to evaluate whether orthodontic services were medically necessary. Prior authorization was a condition for reimbursement of orthodontic services, but did not guarantee payment. The provider was still required to show that the orthodontic procedure was medically necessary under the terms and conditions of the Manual.

To obtain prior authorization, the provider had to submit to TMHP a Handicapping Labio-lingual Deviation (HLD) Index score sheet together with supporting dental records, such as photographs and radiographs. Providers were required by the Manual to submit true, complete, and accurate information to support a request for prior authorization and were also required to maintain patient records for five years.⁸ The HLD Index is an index measuring the existence or absence of handicapping malocclusion and its severity.⁹ It is a tool to measure whether a Medicaid recipient’s dental condition may meet minimum criteria to qualify for

“partnership” are subcontractors of Xerox.

⁴ Tr. Vol. 1 at 58-59.

⁵ Res. Ex. 14 at 19-36 ¶¶ 19.18 and 19.18.1, 19-43 ¶ 19.20 (2008 Manual). The order refers to the 2008 Manual unless the 2008 Manual is substantively different from the 2009, 2010, or 2011 Manual.

⁶ In addition to meeting the 26-point threshold, the child had to have a dysfunctional bite. Tr. Vol. 1 at 60. The age requirement was added in 2009. Res. Ex. 15 at 19-38 ¶ 19.19.1 (2009 Manual).

⁷ HHSC has since transferred the prior authorization and payment of dental services from TMHP to two dental maintenance organizations.

⁸ Res. Ex. 14 at 1-7 and 1-8 ¶ 1.2.3 (2008 Manual).

⁹ Tr. Vol. 3 at 99-10.

orthodontic services, but it neither makes a diagnosis nor prescribes a treatment.¹⁰ The HLD score sheet assigns a certain number of points for nine observed conditions: cleft palate,¹¹ severe traumatic deviations,¹² overjet,¹³ overbite,¹⁴ mandibular protrusion,¹⁵ open bite,¹⁶ ectopic eruption,¹⁷ anterior crowding,¹⁸ and labio-lingual spread.¹⁹ Correction of severe handicapping malocclusion with full banding (braces) generally required a minimum score of 26 points.²⁰ If the HLD Index did not meet the 26-point threshold, a provider could also submit a narrative to establish the medical necessity of the treatment.²¹

The Manual instructed dental providers on how to score their patients on the HLD score sheet. The Manual further instructed providers to be conservative in scoring.²²

B. ADC's Practice

Dr. Nazari has owned ADC since 1998. ADC operates two dental clinics in Houston, Texas, that treated Medicaid and private pay clients. In 2010, approximately 60% to 70% of ADC's patients were Medicaid patients.²³ Dr. Nazari is not an orthodontist. In 2004, ADC hired Dr. Kanaan, an orthodontist.

Between November 1, 2008, and August 31, 2011, ADC provided dental and orthodontic services to Medicaid patients as a Texas Medicaid Provider holding Provider Identification Nos. 1905432, 2187031, 1952657, and 0908162.²⁴

¹⁰ It should be noted that the American Association of Orthodontists has not found any index, including the HLD, to be scientifically valid. Tr. Vol.1 at 222-223.

¹¹ Tr. Vol. 1 at 63.

¹² A head injury involving facial accidents. Res. Ex. 14 at 19-36 ¶ 19.18.1, 19042 ¶ 19.20 (Manual 2008).

¹³ Tr. Vol. 3 at 104.

¹⁴ Tr. Vol. 1 at 65.

¹⁵ Tr. Vol. 1 at 66.

¹⁶ *Id.*

¹⁷ Ectopic eruption is discussed below at pages 12-14.

¹⁸ Tr. Vol. 1 at 211-212.

¹⁹ Tr. Vol. 1 at 67-68.

²⁰ Res. Ex. 14 at 19-36 ¶ 19.18 (2008 Manual).

²¹ Tr. Vol. 1 at 72-73.

²² Res. Ex. 14 at 19-43 ¶ 19.20 (2008 Manual).

²³ Tr. Vol. 3 at 8; Tr. Vol. 4 at 33.

²⁴ ADC's Medicaid provider application and enrollment agreement is at Rex. Ex. 1.

C. The 2008 HHSC-OIG Audit of TMHP

On August 29, 2008, HHSC-OIG issued a performance audit report regarding TMHP's prior authorization process between September 1, 2006, and March 31, 2008 (the 2008 audit report). For some time, HHSC-OIG believed that there were ongoing problems with the orthodontic program because of the substantial rise in program expenditures.²⁵ The purpose of the 2008 audit was determine if TMHP's prior authorization process complied with the Texas Administrative Code, the applicable federal regulations, and its contractual obligations to the Commission.²⁶

According to the 2008 audit report, the prior authorization function was "a utilization management measure allowing payment for only those services that were medically necessary, appropriate, and cost-effective, and reducing the misuse of specified services."²⁷ HHSC-OIG reported that TMHP's prior authorization team failed to review the supporting documentation submitted by providers with the HLD score sheet as required.²⁸ HHSC-OIG also determined that TMHP's staff did not have the dental credentials necessary to evaluate whether the additional documentation supported the HLD score. TMHP's staff referred about 10% of the orthodontic prior authorization requests to the THMP dental director for review. Because of its findings, HHSC-OIG recommended that TMHP increase its training for its preauthorization staff. According to Mr. Millwee, TMHP took no corrective action until September 2011, when it terminated its dental director.²⁹

D. HHSC-OIG's Investigation of ADC

In June 2011, HHSC-OIG began a data analysis of paid Medicaid claims in Texas.³⁰ HHSC-OIG examined providers with the greatest number of prior authorizations and determined that those providers were receiving a large percentage of the Medicaid orthodontic benefits paid in Texas.³¹ ADC ranked in the top 25 providers. HHSC-OIG initiated fraud investigations

²⁵ Tr. Vol. 3 at 195-197.

²⁶ Pet. Ex. 70 Attachment 5, behind Tab 6.

²⁷ Pet. Ex. 70 Attachment 5, behind Tab 6 at P-01451.

²⁸ Tr. Vol. 3 at 196.

²⁹ Pet. Ex. 70 at 74-75.

³⁰ Pet. Ex. 70 at 24 and 36; Tr. Vol. 3 at 195-198.

³¹ Tr. Vol. 3 at 197.

against many of these providers, including ADC. Of the approximately 6,500 cases for which ADC received prior authorization in 2009, 2010, and 2011, using a method of statistical sampling, HHSC-OIG selected 63 cases to audit.³²

After identifying and obtaining the files to be audited, HHSC-OIG sent the physical files to a consulting orthodontist, Dr. Evans, for review and identification of program errors or other problems.³³ HHSC-OIG stated that it also sent field investigators to interview ADC's office staff, dentists providing the services, and patients and their parents/guardians.³⁴

According to HHSC-OIG, for the 63 ADC patients that Dr. Evans reviewed, he concluded that all the HLD scores were inflated.³⁵ Based upon the "100 percent error rate" for the 63 audited cases, HHSC-OIG determined that fraud was involved.³⁶ As a result, HHSC-OIG sent ADC a letter on April 4, 2012, imposing a payment hold on all future claims submitted by ADC to Texas Medicaid, as required under 1 Texas Administrative Code § 371.1703 and 42 C.F.R. § 455.23. According to the letter, the reason for the payment hold was that HHSC-OIG had received "a credible complaint alleging fraud" against ADC for claims it submitted from November 1, 2008 through August 31, 2011.³⁷ ADC timely requested a hearing concerning the payment hold, and the matter was referred to SOAH. During this period, HHSC-OIG also referred ADC to the Medicaid Fraud Control Unit of the Office of Attorney General (MFCU), and on March 29, 2013, MFCU opened an investigation based on HHSC-OIG's allegations of fraud, misrepresentation, and Medicaid program violations.

In May 2012, after the payment hold was imposed, HHSC-OIG retained another orthodontist, Dr. Tadlock, to review ADC's clinical records. Dr. Tadlock found that ADC's clinical records for 62 out of 63 Medicaid patients did not support ADC's HLD score. In all 63 cases, the only scoring component he evaluated was ADC's scoring for ectopic eruptions.

E. HHSC-OIG's Allegations

HHSC-OIG maintains that it was entitled to impose a 100% payment hold against ADC

³² Tr. Vol. at 199-208; Pet. Ex. 82-A.

³³ Tr. Vol. 3 at 209.

³⁴ Tr. Vol. 3 at 209-211.

³⁵ Tr. Vol. 3 at 231.

³⁶ Tr. Vol. 3 at 231-232.

because, as to the period November 1, 2008 through August 31, 2011:

- 1) ADC failed to maintain required records and other documents;
- 2) ADC made false statements to meet prior authorization requirements;
- 3) ADC received payments for services and items that were not reimbursable; and
- 4) HHSC-OIG had credible allegations of fraud supporting the payment hold.

HHSC-OIG also pleaded that ADC committed various non-fraudulent program violations. Without specially identifying patients, HHSC-OIG charged that ADC failed to maintain dental models, HLD score sheets, and treatment notes for dates of services, and failed to provide letters to TMHP for potential extenuating conditions that warranted treatment. By the time of the hearing, HHSC-OIG reduced the number of incidents to the following:

- 6, not 70, dental models;
- 5, not 60, HLD score sheets; and
- 3, not 12, dates of service without corresponding treatment notes.

HHSC-OIG also reduced from 70 to 5 the number of patients under 12 years of age that it alleged improperly received braces.

APPLICABLE LAW

A. Authority to Impose Payment Holds

Medicaid, a joint federal and state program administrated by the states, is governed by a combination of federal and state laws. Three different statutes bear on the issues in this case: Texas Government Code Chapter 531 (which governs the Commission), Texas Human Resources Code Chapter 32 (concerning the medical assistance program generally), and Texas Human Resources Code Chapter 36 (specifically addressing Medicaid fraud prevention).

Texas Government Code § 531-102(g)(2), effective September 1, 2011, mandates that HHSC-OIG impose a hold on payment of claims for reimbursement submitted by a provider on receipt of reliable evidence that the circumstances giving rise to the payment hold involve fraud

³⁷ Pet. Ex. 82-A.

or willful misrepresentation under the state Medicaid program. This statute references the United States' Department of Health and Human Services' regulations at 42 C.F.R § 455.23. The federal rule mandates a suspension of all Medicaid payments to a provider after the state Medicaid agency, in this case HHSC-OIG, determines that there is a credible allegation of fraud for which an investigation is pending, unless the agency has good cause not to suspend payments or to suspend payments only in part.

The federal regulation further provides that, if the state's Medicaid Fraud Control Unit (MFCU) accepts a referral for investigation of the provider, the payment suspension may be continued until the investigation and any associated enforcement proceedings are completed. The state must request quarterly a certification from the MFCU that the matter continues to be under investigation, "thus warranting continuation of the suspension."³⁸

Texas Human Resources Code section 32.0291(b), in effect since 2003, states that, notwithstanding any other law, the Commission may impose a hold on payment of future claims submitted by a provider if there is reliable evidence that the provider has committed fraud or willful misrepresentation regarding a claim for reimbursement under the medical assistance program. Section 32.0291(c) provides that, in a SOAH hearing on a payment hold, the Commission "shall discontinue the hold 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 willful misrepresentation."

The Commission's administrative rules authorize the imposition of a payment hold against a provider prior to the completion of an investigation based on *prima facie* evidence of fraud or willful misrepresentation or of various other violations, including violations not rising to the level of fraud, such as submitting claims for services that are not reimbursable or failing to comply with the terms of the Medicaid program provider agreement.³⁹

B. Percentage Withheld

If HHSC-OIG proves that it had a *prima facie* case to impose a payment hold, then the issue becomes what percentage of future Medicaid payments should be withheld from ADC.

³⁸ 42 C.F.R. § 455.23(d)(3)(ii) (2011).

³⁹ 1 Tex. Admin. Code §§ 371.1703(b)(3), (5), and (6); 371.1617(1)(A)-(C), (I), (K), (2)(A), (5)(A), and G (2005).

Under the federal regulations, if HHSC-OIG establishes that a credible allegation of fraud is being investigated, then the agency “must suspend all Medicaid payments.”⁴⁰ However, the rule allows the agency to deviate from imposing a 100% payment hold to impose either no payment hold or a partial payment hold upon a showing of good cause. The state rules also allow an ALJ or judge of any court competent jurisdiction to order HHSC-OIG to lift the payment hold in whole or in part.⁴¹

C. Fraud, Willful Misrepresentation, and Non-Fraudulent Program Violations

1. Fraud and Willful Misrepresentation

According to the federal regulations, fraud includes an “intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself or some other person.” It includes any act that constitutes fraud under applicable federal or state law.⁴² The elements of fraud are determined by state law.

Chapter 36 of the Texas Human Resources Code specially governs the administrative and judicial enforcement of state civil Medicaid fraud actions. Section 36.002(1) states that it is an unlawful act to knowingly make or cause to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized. “Knowingly” requires the person have knowledge of the information, to act with conscious indifference to the truth or falsity of the information, or to act in reckless disregard of the truth or falsity of the information. Proof of the person’s specific intent to commit an unlawful act under § 36.002 is not required in order to show that a person acted “knowingly.”⁴³ Texas Government Code § 531.1011(1) parrots the federal regulations in defining “fraud” as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person, including any act that constitutes fraud under applicable federal or state law.

⁴⁰ 42 C.F.R. § 455.23(a)(1) (2011).

⁴¹ 1 Tex. Admin. Code § 371.1709(e)(3)(1) (2012).

⁴² 42 C.F.R. § 455.2 (2011).

⁴³ Tex. Hum. Res. Code Ann. § 36.0011(b).

2. Non-Fraudulent Program Violations.

HHSC-OIG is authorized by the Commission's rules to impose a payment hold for program violations.⁴⁴ This includes a provider's failure to maintain patients' records and documentation for the time required by the provider's licensing agency, in this case the Texas Board of Dental Examiners (TBDE), or by the Manual.

ANALYSIS

A. Burden of Proof

HHSC-OIG is *required* to impose a payment hold "on receipt of reliable information that the circumstances giving rise to the hold involve fraud or willful misrepresentation" in accordance with 42 C.F.R. § 455.23.⁴⁵ Section 455.23 of the Code of Federal Regulations provides:

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.⁴⁶

An allegation is credible if it has "indicia of reliability and the State Medicaid Agency has reviewed all allegations, facts, and evidence carefully and acts judicially on a case-by-case basis."⁴⁷

The HHSC-OIG also has additional authority to impose a payment hold for so-called non-fraudulent program violations, including:

- 1) Submitting false statements or misrepresentations when supplying information used to determine a right to payment, to obtain greater compensation, or to meet prior authorization requirements;⁴⁸

⁴⁴ 1 Tex. Admin. Code § 371.1617.

⁴⁵ Tex. Gov't Code Ann. § 531.102(g)(2).

⁴⁶ 42 C.F.R. § 455.23(a)(1) (emphasis added).

⁴⁷ 42 C.F.R. § 455.2.

⁴⁸ 1 Tex. Admin. Code § 371.1617(1)(A)-(C), (I)

- 2) Submitting claims that are not reimbursable by Medicaid;⁴⁹
- 3) Failing to maintain for five years documentation the provider is required to maintain, or failing to provide the documentation to the Inspector General on written request;⁵⁰ and
- 4) Failing to comply with the terms of Medicaid provider agreement, provider policy, or procedure manuals.⁵¹

Based on expert review of ADC patient records by orthodontic experts retained by the State and its own field investigation, the HHSC-OIG imposed a payment hold based on its determination that *prima facie* evidence existed that ADC:

- 1) Fraudulently or willfully misrepresented HLD scores in prior authorization (PA) requests, in violation of Tex. Gov't Code § 531.102(a) and 1 Tex. Admin. Code § 371.1617(1)(A), (B), and (I);
- 2) Billed for services not reimbursable, in violation of 1 Tex. Admin. Code § 371.1617(1)(K); and
- 3) Failed to maintain and provide required records, in violation of 1 Tex. Admin. Code § 371.1617(2)(A).⁵²

ADC, as a result, also failed to comply with Medicaid program policies, in violation of 1 Tex. Admin. Code § 371.1617(5)(A) and (G).⁵³

1. The Inspector General presented *prima facie* evidence that is relevant, credible, and material, that ADC committed fraud or made willful misrepresentations.



In order to maintain the payment hold based on credible allegations of fraud, the Inspector General bore the evidentiary burden to show by *prima facie* evidence⁵⁴ that is relevant, credible, and material, that ADC committed fraud or willful misrepresentation in connection with

⁴⁹ *Id.* At (1)(K).

⁵⁰ *Id.* at (2)(A).

⁵¹ *Id.* at (5)(A), (5)(G).

⁵² Res. Ex. P-82a.

⁵³ *Id.*

⁵⁴ “Prima facie” evidence, is evidence that, until its effect is overcome by evidence, will suffice as proof of a fact in issue.” *Rehak Creative Servs. v. Witt*, 404 S.W. 3d 716, 726 (Tex. App. – Houston [14th Dist.] 2013, pet. denied) (citing *Duncan v. Butterowe, Inc.*, 474 S. W. 2d 619, 621 (Tex. Civ. App. – Houston [14th Dist.] 1971, no wit)).

its orthodontia PA requests and claims.⁵⁵

The evidence established that the HHSC-OIG initiated this investigation of ADC in 2011.⁵⁶ During the time period of the investigation, ADC treated approximately 6,550 Medicaid patients.⁵⁷ In order to conduct his investigation, the Inspector General collected from ADC a statistically valid random sample of 63 patient files from the population of Medicaid patients treated during the time period covered by the investigation (2008-2011).⁵⁸ The 63 files were reviewed by two OIG experts: Dr. Charles Evans and Dr. Larry Tadlock.

Both State experts, using the Manuals for the corresponding years of service (2008-2011) concluded ADC inflated HLD scores submitted to Medicaid.⁵⁹

Among other things, the Inspector General presented the following evidence:



- Of the 63 patients in the sample, ADC scored 61 (or 96.8%) as having severe handicapping malocclusions, *i.e.*, severely extreme deviations from the norm.⁶⁰
- ADC certified that every single one of these 61 patients have six or more ectopically-erupted teeth.⁶¹
- ADC scored 50% or more of the allowable teeth as ectopic on each and every sample HLD score sheet ADC submitted for comprehensive orthodontics authorization.⁶²
- Not a single patient in the sample was eligible for Medicaid coverage comprehensive orthodontics without ADC's scoring for ectopic eruption; alternatively, ACD did not submit any narratives for any of the 61 patients, even if services could be justified on other bases.⁶³
- ADC is the subject of at least three investigations by the Inspector General for

⁵⁵ Tex. Hum. Res. Code Ann. § 32.0291(c).

⁵⁶ Tr. Vol. 3 at 195.

⁵⁷ Tr. Vol. 3 at 200.

⁵⁸ Tr. Vol. 3 at 202-208.

⁵⁹ Tr. Vol. 3 at 289-96.

⁶⁰ See summary attached to Inspector General's Closing Argument, Attachment 6, Res. Ex. R49.

⁶¹ Res. Ex.P-64.01 through P-64.63.

⁶² See summary attached to Inspector General's Closing Argument, Attachment 6, Ex. R49.

violations of Texas Medicaid regulations.⁶⁴

Dr. Larry Tadlock, the expert witness who testified on behalf of HHSC-OIG, is both a practicing orthodontist and an associate clinical professor at the Baylor College of Dentistry (now Texas A&M College of Dentistry).⁶⁵ He has assisted in scoring numerous HLD score sheets and has examined several hundred HLD score sheets.⁶⁶ He is board certified in orthodontics and is a director of the American Board of Orthodontists.⁶⁷ He was retained in this case by HHSC-OIG to review 63 patient files.⁶⁸ Dr. Tadlock scored only 59 out of 63 files because four of them failed to contain an HLD score sheet.⁶⁹

The Manual permits a score of three points for each tooth that is found to be “ectopically erupted.”⁷⁰ While ADC contended that 58 out of 59 cases scored an HLD index of 24 or more points for ectopic eruption, Dr. Tadlock testified that, *on the basis of his own practice*, as well as the relevant literature, such findings were mathematically dubious. In response to the question of whether a single patient might present with multiple ectopic teeth, he testified that the possibility was “less than one percent,” and that it was simply not possible for a patient to present with eight ectopic teeth as claimed by ADC.⁷¹ While both ADC and SOAH challenged the credibility of Dr. Tadlock relating to his scoring of the ADC files he reviewed, neither challenged his credibility on the matter of his experience regarding the possibility of multiple ectopically-erupted teeth.

Dr. Wael Kanaan, a practicing orthodontist and an employee of ADC, was interrogated about specific files in which he found a total HLD index score of at least 26, and a score of 24 for teeth that were ectopically erupted. Dr. Kanaan not only found the requisite HLD score to qualify for Medicaid reimbursement, *he found them on precisely the same teeth on a large number of patients—i.e.*, the four upper and lower incisors. After being questioned about 20

⁶³ Res. Ex. P-64.01 through P64.63; Tr. Vol. 4 at 70.

⁶⁴ Tr. Vol. 3 at 194-95.

⁶⁵ Tr. Vol. 1 at 127-128.

⁶⁶ Tr. Vol. 1 at 131-132.

⁶⁷ Tr. Vol. 1 at 133.

⁶⁸ Tr. Vol. 1 at 137; Tr. Vol. 1 at 164.

⁶⁹ Tr. Vol. 1 at 168.

⁷⁰ Res. Ex. 14 at 19-43 ¶ 19.20.1 (2008 Manual).

⁷¹ Tr. Vol. 1 at 174-175.

HLD score sheets and 19 patients, Dr. Kanaan answered that, of that number, 17 had scored 24 points for ectopic eruption, and he testified further that all 17 had precisely the same teeth described as ectopic.⁷² Remarkably, Dr. Kanaan denied seeing a suspicious pattern in these results.⁷³

Subsequently, Dr. Kanaan acknowledged that 20 of 23 patients had these same identical scores. Finally, he contended that 25 of 29 patients had identical scores with identical teeth, and yet denied seeing a pattern in those findings.⁷⁴

At the same time he was scoring 25 of 29 patients with identical HLD scores for ectopic eruption, Dr. Kanaan claimed that he “was following the manual and the manual says to be conservative.”⁷⁵ Neither ADC offered any evidence nor did the SOAH ALJs make a finding of fact regarding Dr. Kanaan’s definition of the word “conservative” in the relevant context. Nor did either explain how ADC construed the concept of “conservatism” in scoring teeth.

Dr. Kanaan also stated that he “absolutely” does not “diagnose Medicaid patients in a different manner than you diagnose private pay patients.”⁷⁶ And yet, in subsequent testimony, in answer to a question about what percentage of his private pay patients had ectopic eruption, he testified that he did not “use a concept of ectopic eruption for his private pay patients.”⁷⁷

Finally, there appears to be some discrepancy in some of the questions posed to Dr. Kanaan and his answers. The SOAH ALJs incorrectly assert that Dr. Kanaan concluded that Patients 36, 37, 42, 43, and 47 each presented a “severe handicapping malocclusion.”⁷⁸ Of these patients, the only ones for which Dr. Kanaan made such a statement are Patients 36 and 47.⁷⁹ He described Patient 36 as a “100 percent dysfunctional handicapping case” and Patient 4 as having “hundred percent handicap malocclusion.”⁸⁰ For each of the other 5 patients, Dr. Kanaan merely stated that the patient, in his opinion, needed orthodontic treatment. For these three patients, Dr.

⁷² Tr. Vol. 3 at 63.

⁷³ *Id.*

⁷⁴ Tr. Vol. 3 at 70.

⁷⁵ Tr. Vol. 3 at 80.

⁷⁶ Tr. Vol. 3 at 17.

⁷⁷ Tr. Vol. 3 at 96.

⁷⁸ PFD at 27.

⁷⁹ Tr. Vol. 1 at 149.

⁸⁰ Tr. Vol. 3 at 161-62.

Kanaan stated that these patients, had a “true orthodontic need for braces.”⁸¹ This distinction is more than a semantic one, as the standard for Medicaid coverage is “severe handicapping malocclusion” and not merely one of “true orthodontic need.”⁸²

I find the testimony of Dr. Tadlock, with regard to his experience with his own patients, to have been sufficiently credible to furnish *prima facie* evidence for HHSC-OIG to have proceeded with the hearing. On the other hand, Dr. Kanaan’s repeated finding of 24 points of ectopic eruption on 24 of 29 patients, and on the same precise teeth in each case, and his failure to acknowledge a pattern in such scoring, makes plain that Dr. Kanaan’s testimony, the primary witness on which ADC relied to make its case, demonstrates a reckless disregard of his scoring technique.

2. One of ADC’s expert witnesses, Dr. Ornish, failed to score 26 points on 17.5 percent of the cases he reviewed.

One of ADC’s expert witnesses, Dr. Ornish, on whom the SOAH ALJ’s declined to rely, testified that 11 patients, of a total of 63, did not qualify for Medicaid reimbursement because their total score did not reach 26 points.⁸³ And yet the SOAH ALJs found that the testimony of both Dr. Ornish and Dr. Orr, ADC’s other expert, was merely “cumulative of the testimony of Drs. Nazari and Kanaan.”⁸⁴ According to the PFD, “[t]hese differences in professional judgment do not prove fraud or intentional inflated scoring by ADC.”

It is difficult for the ALJ to conclude that a discrepancy of 17.5 percent amounts to testimony that is merely “cumulative.” Rather, it appears to be at odds with the testimony of Drs. Nazari and Kanaan.

3. The Inspector General presented *prima facie* evidence that ADC billed Medicaid for services that are not reimbursable. Moreover, ADC failed extensively to maintain proper records, and yet the SOAH ALJs, while characterizing these program violations as ranging from “very innocuous” to “very important,” failed to deduct any points from ADC’s 100 percent payment hold.

Unless an exception applies, Texas Medicaid only covers comprehensive orthodontics for patients “who are 12 years of age and older or clients who have exfoliated all primary

⁸¹ Tr. Vol. 3 at 156-59.

⁸² See 1 Tex. Admin. Code § 33.71(a).

⁸³ Petitioner’s Supp. Ex. P-72 and P-73.

⁸⁴ PFD, at 28.

dentition.”⁸⁵ ADC wrongly sought and received reimbursement for comprehensive orthodontic treatment (D8080) for three patients in the 63 patient sample (4.76%) who were under 12 years of age and who had primary (baby) teeth.⁸⁶ Therefore, ADC violated 1 Tex. Admin. Code § 371.1617(1)(K) and (5)(G).

Contrary to the PFD, these patients had retained primary (baby) teeth with no indication on the submitted treatment plan that ADC intended to extract the primary teeth as required in 19.19.1 of the 2009 edition of the Manual: “Full banding is allowed on permanent dentition only, and treatment should be accomplished in one state and is allowed once per lifetime. Exceptions: Cases of mixed dentition when the treatment plan includes extractions of remaining primary teeth or cleft palate.” Further, ADC sought approval to treat them for comprehensive orthodontics, not interceptive or limited orthodontics, and ADC did not contend that this exception applied to the patients to warrant billing for D8080.⁸⁷ In contrast to these three patients, who were submitted under the D8080 code, the record shows that ADC knew how to submit a claim for purely interceptive treatment when it wanted to.⁸⁸

Providers voluntarily agree “to maintain records and provide access to and copies of such records.”⁸⁹ Failure to maintain or provide records is a program violation.⁹⁰ The HHSC-OIG presented evidence—and indeed, the SOAH ALJs found—that ADC failed to keep necessary records for the required 5-year period.⁹¹ ADC failed to maintain and/or provide investigators with the following records for patients in the 63-patient sample:

- HLD forms (5 patients, or 7.9% of the sample);
- Pre-treatment x-rays (2 patients, or 3.2% of the sample);
- Extraction requests (6 patients, or 9.52% of the sample);
- Treatment cards (6 patients, or 9.52% of the sample); and

⁸⁵ Res. Ex. R-15 at § 19.19.1 (2009).

⁸⁶ Res. Exs. P-15 at P15-0019, P-56 at P56-0015, P-60 at P-60-0004 (ADC Prior Authorization Request Forms for underage Patients 15, 56, and 60, respectively, requesting “D8080”); R.R. Vol. 4 at 54:8-14.

⁸⁷ PFD at 34.

⁸⁸ Res. Ex. P10-0005, and P10-0006 (patients submitted for interceptive treatment under code D8060).

⁸⁹ R-01 at 0024.

⁹⁰ 1 Tex. Admin. Code § 371.1617(2)(A).

⁹¹ 22 Tex. Admin. Code § 108.8(b).

- Models (4 patients, or 6.3% of the sample).

The record reflects, then, by *prima facie* evidence that—

- 1) A substantial number of the PA requests submitted by ADC in the sample include false statements or material misrepresentations;
- 2) ADC made claims for comprehensive orthodontia (full banding) for three patients in the sample who were not eligible; and
- 3) ADC failed to maintain proper records in 23 instances in the sample.

* * * *

CONCLUSIONS AND RECOMMENDATIONS

In light of numerous discrepancies between the PFD and the evidence in this case, the ALJ specifically excepts to certain findings of fact and conclusions of law. Of the fifty-seven findings of fact set out in the PFD, the ALJ accepts thirty-nine and modifies eighteen. Of the sixteen conclusions of law set out in the PFD, the ALJ accepts eleven and modifies five as follows:

FINDINGS OF FACT

Background

1. Behzad Nazari, D.D.S., has owned Antoine Dental Center (ADC) since 1998. ADC has two dental clinics in Houston, Texas, that treat Medicaid and private pay clients.
2. Between November 1, 2008, and August 31, 2011, ADC provided dental and orthodontic services to Medicaid patients as a Texas Medicaid Provider holding Provider Identification Nos. 1905432, 2187031, 1952657, and 0908162.
3. During this period, ADC billed Texas Medicaid approximately \$8,104,875.75 for orthodontic services.
4. In 2010, approximately 70% of ADC's patients were Medicaid patients.
5. The federal government and the State of Texas share the cost of Texas Medicaid, with the federal government contributing approximately 60% of the payments for Medicaid services.

6. The Texas Health and Human Service Commission (the Commission) is the single agency responsible for the administration of the Texas Medical Assistance Program (Texas Medicaid) and does so by contracting with healthcare providers, claims administrators, and other contractors.
7. During the times in question in this case, Texas Medicaid & Healthcare Partnership (TMHP) was the contracted Texas Medicaid claims administrator.
8. During all applicable periods, the Commission's Office of Inspector General (HHSC-OIG) was responsible for monitoring and investigating allegations of fraud, waste, and abuse associated with the Texas Medicaid program.
9. As part of the enrollment process, a provider agreed to comply with the terms of the annual Texas Medicaid Provider Procedures Manual (Manual) and the bulletin updates issued every two months.
10. Proposed FoF No. 10 states: *According to the Manual, the intent of the Medicaid dental program was to provide dental care to clients 20 years of age or younger.*

Proposed FoF No. 10 is erroneous because it misstates Medicaid policy, as codified in 25 Tex. Admin. Code § 33.71.

The ALJ therefore substitutes the following for SOAH's Proposed FoF No. 10:

Medicaid orthodontia services are limited to treatment of children aged 12 to 20 years with severe handicapping malocclusion and other related conditions, unless an exemption is expressly sought by the provider.

11. In 2008 through 2011, Texas Medicaid paid the providers of orthodontic services on a fee-for-service basis.
12. To be reimbursed for orthodontic services, the Manual required dental providers to first obtain prior authorization from TMHP.
13. In making prior authorization decisions in orthodontia cases, TMHP relied in part on a Handicapping Labio-lingual Deviation (HLD) score sheet contained in the Manual to determine whether orthodontic services qualified for Medicaid coverage.
14. The Manual required providers to complete and submit the HLD score sheet to TMHP together with a prior authorization request and the supporting clinical materials including the treatment plan, cephalometric radiograph with tracing models, facial photographs, radiographs, the model (or cast) of the patient's teeth if a model was made, and any additional pertinent information to evaluate the request.
15. The HLD Index is an index measuring the existence or absence of handicapping malocclusion and its severity, and is a tool used by Medicaid to measure whether a patient

qualifies for the public funding program. It is not intended to be a diagnostic or treatment tool.

16. The Manual described the categories of the HLD Index, and instructed providers on how to score those categories.
17. The HLD score sheet assigned a certain number of points for the following observed conditions: cleft palate, severe traumatic deviations, overjet, overbite, mandibular protrusion, open bite, ectopic eruption, anterior crowding, and labio-lingual spread in millimeters.
18. Orthodontic services provided solely for cosmetic reasons were not covered under the Texas Medicaid program.
19. Although Texas Medicaid generally restricted orthodontic treatment to children 12 years of age or older who no longer had primary teeth, a provider could request that TMHP approve prior authorization for interceptive treatment or for treatment for a child who qualified for another exception under the program.
20. In general, orthodontic benefits were limited to the treatment of children 12 years of age or older with a severe handicapping malocclusion. If the HLD Index score did not meet the 26-point threshold, a provider could submit a narrative to establish the medical necessity of the treatment.
21. Proposed FoF N. 21 states: *TMHP was responsible for reviewing the filed material to evaluate whether the orthodontic services were medically necessary before granting prior authorization.*

This FoF is not relevant and rests upon an incorrect legal premise.⁹² The proposed finding ignores the responsibility expressly stated in the Provider Agreement and agreed to by ADC and/or its providers), including accurate HLD score sheets and Prior Authorizations. ADC produced no evidence or legal authority to show it was somehow allowed to provide fraudulent or false statements, submit claims for unreimbursable services, or engage in any conduct in violation of the applicable Medicaid program rules, based on the mere fact TMHP approved ADC's prior authorization claims. The Texas Supreme Court unequivocally has held the State "is not subject to the defenses of limitations, laches, or estoppel."⁹³

The ALJ therefore substitutes the following for SOAH's FoF No. 21:

Notwithstanding TMHP's responsibility for reviewing the filed material to evaluate whether the orthodontic services were medically necessary before granting prior authorization, ADC was required to submit accurate HLD score sheets and PA

⁹² See *State v. Durham*, 860 S.W.2d 63, 67 (Tex. 1993).

⁹³ *Id.*

requests substantiating the patient's condition as meeting Medicaid's requirements.

22. The Manual clarified that prior authorization of an orthodontic service did not guarantee payment. To receive payment, the provider still had to show that the orthodontic procedure was medically necessary under the terms and conditions of the Manual.
23. After ADC provided the orthodontic treatment to the patients in this case, TMHP approved payment.

2008 HHSC-OIG Audit of TMHP

24. On August 29, 2008, HHSC-OIG issued a performance audit report regarding TMHP's prior authorization process for the period between September 1, 2006, and March 31, 2008, finding that TMHP's prior authorization process did not comply with the Manual (the 2008 audit report).
25. In the 2008 audit report, HHSC-OIG found that TMHP's prior authorization staff failed to review the supporting material submitted by providers with their prior authorization requests, as required, and that TMHP's staff did not have the dental credentials necessary to evaluate whether the supporting documentation submitted by providers supported the HLD score.
26. Proposed FoF No. 26 states: *ADC was unaware of the 2008 audit report and HHSC-OIG's assertion that TMHP was not properly performing prior authorization evaluations.*

This FoF is not relevant and rests upon an incorrect legal premise.⁹⁴ The proposed finding ignores the responsibility ADC had to submit truthful documentation to the State, including accurate HLD score sheets and PAs. (ADC produced no evidence or legal authority to show it was somehow allowed to provide fraudulent or false statements, submit claims for unreimbursable services, or engage in any conduct in violation of the applicable Medicaid program rules, based on the mere fact TMHP approved ADC's prior authorization claims). The Texas Supreme Court unequivocally has held the State "is not subject to the defenses of limitations, laches, or estoppel."⁹⁵

The ALJ therefore adopts the following substitute for SOAH's Proposed FoF No. 26:

The Provider Agreement required ADC and its providers to certify to be truthful, to abide by the Medicaid rules, and to submit true, complete, and accurate information that can be verified by reference to source documentation maintained by ADC.

HHSC-OIG's Investigation of ADC

27. In 2011, HHSC-OIG conducted a data analysis of paid Medicaid claims in Texas and

⁹⁴ *Id.*

⁹⁵ *Id.*

determined that ADC was one of the top providers in the state with high utilization of orthodontia billing between 2008 and 2011. As a result, HHSC-OIG initiated a fraud investigation against ADC.

28. HHSC-OIG retained Charles Evans, D.D.S., an orthodontist, to review the clinical records for the 63-patient sample collected by HHSC-OIG for whom ADC filed prior authorization requests during the relevant period.
29. Proposed FoF No. 29 states: *The HLD score sheets for the 63 patients were completed by ADC's orthodontist, Wael Kanaan, D.D.S. and Dr. Nazari, and in each case the patient scored 26 or more points. The greatest number of points was associated with the category of "ectopic eruption."*

Proposed FoF No. 29 is erroneous because it misstates the facts on the record. Drs. Kanaan and Nazari scored the HLD score sheets and represented to the State the accuracy of the scores. Also, Dr. Nazari is not an orthodontist.



The ALJ therefore substitutes the following for SOAH's FoF No. 29:

The HLD score sheet for the 63 patients were completed by ADC's orthodontist, Wael Kanaan, D.D.S. and Dr. Nazari, who is not an orthodontist, and in each case they scored the patient as having a score of 26 or more points. The greatest number of points was associated with the category of "ectopic eruption."

The Manual requires providers to apply the HLD scoring methodology in accordance with their professional training, education, and generally accepted standards in the dental profession. Among those standards is the standard for identifying ectopic eruption.

30. Dr. Evans concluded that, in all 63 cases, the clinical records did not support the scoring on the HLD score sheets submitted with the prior authorization requests because of the score assigned to the ectopic eruption category. Dr. Evans did not testify in this matter.
31. Although HHSC-OIG represented that its field investigators interviewed ADC's office staff, dentists, and the patients and their parents/guardians, it did not present this evidence during the hearing.
32. Based in large part on Dr. Evans' conclusions, on April 4, 2012, HHSC-OIG issued a letter to ADC notifying ADC that it was imposing a 100% payment hold on all future Medicaid reimbursements due to a credible allegation of fraud for claims ADC submitted from November 1, 2008 through August 31, 2011.
33. ADC timely requested a hearing to contest the payment hold, and the matter was referred to the State Office of Administrative Hearings (SOAH) on November 7, 2012.
34. HHSC-OIG referred ADC to the Medicaid Fraud Control Unit of the Office of the Attorney

General (MFCU), and on March 29, 2012, MFCU opened an investigation.

35. On January 15, 2013, HHSC-OIG issued its First Amended Notice of Hearing to ADC. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short plain statement of the matters asserted.
36. The hearing on the merits was held May 28 through 31, 2013, before Administrative Law Judges Catherine C. Egan and Howard S. Seitzman at the State Office of Administrative Hearings (SOAH) in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. ADC appeared through its attorneys of record, J .A. Tony Canales, Hector Canales, Robert M. Anderton, Philip H. Hilder, William B. Graham, James G. Rytting, and Thomas Watkins. HHSC-OIG was represented by outside counsel Dan Hargrove, Caitlyn Silhan, James R. Moriarty, Ketan Kharod; by Assistant Attorneys General Raymond C. Winter and Margaret M. Moore, from the Office of Attorney General of Texas, and by Enrique Varela and John R. Medlock, from HHSC-OIG.

Ectopic Eruption

37. In the 2008 through 2011 Manuals (Manuals), the HLD index described the term “ectopic eruption” as “an unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge.” The Manuals instructed providers not to include (score) teeth from an arch if the provider counted the arch in the category for anterior crowding. For each arch, the Manual further instructed that either the ectopic eruption or anterior crowding could be scored, but not both.
38. The Manuals’ references to high labial cuspids and teeth grossly out of the long axis of the alveolar ridge were nonexclusive examples of ectopic eruption.
39. The Manuals’ definition of ectopic eruption in the 2008 through 2011 Manual required subjective judgment to interpret.
40. Proposed FoF No. 40 states: *The Manual’s definition of ectopic eruption was amended, effective January 2, 2012 (2012 Manual), to include the following sentence; 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.*

Proposed FoF No. 40 addresses a mixed question of fact and law, and is a so-called “legislative finding.” Therefore, the Administrative Law Judge, as provided by Executive Commissioner’s delegation of authority, has complete discretion to modify it.⁹⁶



The ALJ substitutes the following for SOAH’s Proposed FoF No. 40:

⁹⁶ *Id.*

The Manual’s instruction regarding ectopic eruption was amended effective January 2, 2012 (2012 Manual), to include the following sentence: 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. This amendment clarified existing Texas Medicaid policy regarding conditions qualifying as ectopic eruption and did not substantively change Texas Medicaid policy.



41. Proposed FoF No. 41 states: *The language in the Manuals provided a definition of ectopic eruption solely for use in scoring the HLD index to qualify for payment.*

Proposed FoF No. 41 addresses a mixed question of fact and law, and is a so-called “legislative finding.” Therefore, the Administrative Law Judge, as provided by the Executive Commissioner’s delegation of authority, has complete discretion to modify it.⁹⁷

The ALJ substitutes the following for SOAH’s FoF No. 41:

The language in the Manuals provided instructions to dentists and orthodontists to score ectopic eruption consistently with the standard for ectopic eruption that are generally recognized in the dental profession.



42. Proposed FoF No. 42 states: *The Manuals did not address how an orthodontist diagnosed or treated a patient, but only defined ectopic eruption for scoring the HLD score sheet to determine a Texas Medicaid patient’s eligibility for orthodontic treatment.*

Proposed FoF No. 42 addresses a mixed question of fact and law, and is a so-called “legislative finding.” Therefore, the Administrative Law Judge, as provided by the Executive Commissioner’s delegation of authority, has complete discretion to modify it.⁹⁸

The ALJ substitutes the following for SOAH’s Proposed FoF No. 42:

The Manual did not address how an orthodontist diagnosed or treated a patient, but only instructed providers to score anterior teeth consistently with the generally understood definition of ectopic eruption in the orthodontic profession.



43. After HHSC-OIG imposed the payment hold on ADC, it hired Larry Tadlock, D.D.S., an orthodontist, to review the 63 patients previously reviewed by Dr. Evans.

44. Proposed FoF No. 44 states: *After reviewing the patients’ HLD score sheets, Dr. Tadlock found only one patient, Patient 15, who met the 26-point threshold.*

Proposed FoF No. 44 is erroneous. While Dr. Tadlock did assign an HLD score of greater than 26 to Patient 15, it is factually incorrect to state that “ectopic eruptions” scored 26 points for this patient. The record shows Dr. Tadlock assigned a score of 28 to



⁹⁷ *Id.*

⁹⁸ *Id.*

Patient 15, but zero points of that total comprised points for ectopic eruption. *See* Res. Ex. P-77 (reflecting HLD score of 28 for Dr. Tadlock), R-49 (reflecting HLD score of 28, with 0 points for ectopic eruption).



The ALJ substitutes the following for SOAH's Proposed FoF No. 44:

After reviewing the patients' HLD score sheets, Dr. Tadlock found one patient (Patient 15) with an HLD score of 26 points or higher.

45. Proposed FoF No. 45 states: *Dr. Tadlock did not apply the [2008-2011] Manuals' definition of ectopic eruption in scoring the HLD index for the 63 ADC patients.*

Proposed FoF No. 45 is erroneous, because the proposed finding misconstrues Dr. Tadlock testimony. In fact, Dr. Tadlock's testimony shows that in his view, the Manuals' instructions are consistent with the generally understood definition of ectopic eruption.⁹⁹ These errors reflect a misinterpretation of law and policy by the SOAH ALJs, as well as a fundamental misunderstanding of Dr. Tadlock's testimony.



Proposed FoF No. 45 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Administrative Law Judge, as provided by the Executive Commissioner's delegation of authority, has complete discretion to modify it.¹⁰⁰

The ALJ substitutes the following for SOAH's Proposed FoF No. 45:

In reviewing the 63 ADC patient files Dr. Tadlock applied the definition of ectopic eruption that is generally recognized within the dental profession and scored the patients as instructed by the Manuals. Dr. Tadlock properly applied Medicaid policy.



46. Proposed FoF No. 46 states: *Dr. Nazari was a credible witness and properly utilized the Manuals' definition in scoring the HLD index.*

Proposed Finding of Fact No. 46 is erroneous because the proposed finding ignores evidence that directly refutes Dr. Kanaan's credibility, specifically Dr. Tadlock's testimony that Dr. Kanaan's scoring represents a pattern, the odds of which occurring are "zero." Moreover, the proposed finding of fact ignores the inconsistencies in Dr. Kanaan's own testimony—*e.g.*, his contradictory use of ectopic eruption in diagnosing Medicaid and non-Medicaid patients, his unwillingness to acknowledge a suspicious pattern of treatment even after his admission that 25 of 29 sampled patients received virtually identical diagnoses.



⁹⁹ R.R., Vol. 1, 202:21-203:10.

¹⁰⁰ *Tex. State Bd. of Dental Examiners v. Brown*, 281 S.W.3d 692 (Tex. App. -- Corpus Christi 2009, pet. denied); *Froemming v. Tex. State Bd. of Dental Examiners*, 380 S.W.3d 787 (Tex. App. -- Austin 2013, no pet.).

The ALJ substitutes the following for SOAH's Proposed Finding of Fact No. 46:

Despite the ALJs finding Dr. Nazari's testimony to be credible, Dr. Nazari did not properly follow Medicaid policy in his identification of ectopic eruptions; the overwhelming evidence of the consistent pattern of inflated HLD scores submitted by ADC establishes *prima facie* evidence that is reliable, relevant and material that ADC's misrepresentations of medical necessity constitute willful misrepresentations.

47. Proposed FoF No. 47 states: *Wael Kanaan, DDS an orthodontist who worked with ADC was a credible witness and properly utilized the Manuals' definition of ectopic eruption in scoring the HLD index.*



Proposed FoF No. 47 is erroneous because the proposed finding ignores evidence that directly refutes Dr. Kanaan's credibility, specifically Dr. Tadlock's testimony that Dr. Kanaan's scoring represents a pattern, the odds of which occurring are "zero." Moreover, the proposed finding of fact ignores the inconsistencies in Dr. Kanaan's own testimony—*e.g.*, his contradictory use of ectopic eruption in diagnosing Medicaid and non-Medicaid patients, his unwillingness to acknowledge a suspicious pattern of treatment even after his admission that 25 of 29 sampled patients received virtually identical diagnoses.

Proposed FoF No. 47 also addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Administrative Law Judge, as provided by the Executive Commissioner's delegation of authority, has complete discretion to modify it.¹⁰¹

The ALJ substitutes the following for SOAH's Finding of Fact No. 47:

Despite the ALJs finding Dr. Kanaan's testimony to be credible, Dr. Kanaan did not properly follow Medicaid policy in his identification of ectopic eruptions; the overwhelming evidence of the consistent pattern of inflated HLD scores submitted by ADC establishes *prima facie* evidence that is relevant, credible, and material that ADC's misrepresentations of medical necessity constitute willful misrepresentations.

48. Proposed FoF No. 48 states: *There is no evidence that is credible, reliable, or verifiable, or that has indicia of reliability, that ADC incorrectly scored the HLD index to obtain benefits for patients or to obtain Texas Medicaid payments.*

Proposed FoF No. 48 is erroneous because it ignores the weight of the evidence in this case and misapplies Texas law and Medicaid policy.

First, the proposed finding misapplies law and Medicaid policy by stating that there is no evidence that ADC incorrectly scored the HLD index. In fact, the only credible evidence is that the HLD scores submitted by Drs. Nazari and Kanaan were incorrect because of

¹⁰¹ *Id.*, 2003 WL 21401591, at *8.

their interpretation of ectopic eruption.¹⁰²

The totality of the evidence, which includes the testimony as the ADC's own witnesses, as well as the HHSC-OIG's experts, is much more than *prima facie*, and is relevant, credible, and material.¹⁰³ The evidence is also reliable. The proposed finding is erroneous, because implicit in it are assumptions that the definition of ectopic eruption is open to subjective interpretation and that Texas Medicaid adopted a "special" definition of ectopic eruption that was more liberal than the generally accepted definition of ectopic eruption in the orthodontic profession. These errors reflect misapplications of law and Medicaid policy by the SOAH ALJs.

Finally, this proposed FoF reflects a further misapplication of law in suggesting that the HHSC-OIG bears the burden of proving intent to defraud Medicaid. As the SOAH ALJs acknowledge in the narrative section of their PFD, the HHSC-OIG does not have the burden to show specific intent to defraud the Medicaid program in order to show that ADC has committed an unlawful act under Human Resources Code chapter 36, the Texas Medicaid Fraud Prevention Act.¹⁰⁴

Nevertheless, in proposed FoF No. 48, the SOAH ALJs write that the HHSC-OIG is required to demonstrate relevant, credible, and material evidence that ADC knowingly, recklessly, or with conscious indifference submitted scores that overstated the child's true condition. Drs. Kanaan and Nazari acknowledge that they applied an interpretation of ectopic eruption that does not comport with Medicaid policy.¹⁰⁵ To the extent that the SOAH ALJs attempt to hold the HHSC-OIG to the additional burden of proving intent on the part of ADC to defraud the Medicaid program, proposed FoF No. 48 is erroneous.

Furthermore, Proposed FoF No. 48 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Administrative Law Judge, as provided by the Executive Commissioner's delegation of authority, has complete discretion to modify it.¹⁰⁶

The ALJ substitutes Proposed Finding of Fact No. 48 with the following:

HHSC-OIG presented evidence that is credible, reliable, and verified, and that has indicia of reliability that ADC knowingly incorrectly scored the HLD index on orthodontic prior approval requests submitted to Texas Medicaid.

49. Proposed FoF No. 49 states: *There is no evidence that is credible, reliable, or verifiable,*

¹⁰² See, e.g., testimony of Dr. Tadlock at Tr.Vol. 173 at 173, 174-177; testimony of Dr. Nazari, Tr. Vol. 4 at 144-45; testimony of Dr. Kannan, Tr Vol. 3 at 43-70.

¹⁰³ See Hum. Res. Code Ann. § 32.0291(c).

¹⁰⁴ See PFD at 15, citing definition of "knowingly" at section 36.0011 of the TMFPA.

¹⁰⁵ See Tr. Vol. 1 at 173-77; Tr. Vol. 3 at 43-70; Tr. Vol. 4 at 144-45.

¹⁰⁶ *Tex. State Bd. of Dental Examiners v. Brown*, 281 S.W.3d 692 (Tex. App. -- Corpus Christi 2009, pet. denied); *Froemming v. Tex. State Bd. of Dental Examiners*, 380 S.W.3d 787 (Tex. App. -- Austin 2013, no pet.).

or that has indicia or reliability, that ADC engaged in willful misrepresentation with respect to the 63 ADC patients in this case.

Proposed FoF No. 49 is erroneous, because it ignores the weight of the evidence in this case and it misapplies Texas law and Medicaid policy.

First, the proposed finding misapplies Texas law governing HHSC-OIG's burden of proof in this case. As noted in CoL No. 12, to maintain the payment hold, HHSC-OIG need only make a *prima facie* showing of evidence that is credible, reliable, or verifiable, or that has indicia of reliability that ADC has committed fraud or willful misrepresentations in this case. The SOAH ALJs' determination that HHSC-OIG presented "no evidence" on this issue ignores the expert testimony of Dr. Tadlock and is fatally tainted by the SOAH ALJs' legally erroneous interpretation of Medicaid policy with respect to the definition of ectopic eruption.



As noted in these determinations, the ALJs' determinations that—

(1) Texas Medicaid "defined" ectopic eruption uniquely and differently in the Manual than the generally accepted definition in the orthodontic professions;

(2) Said definition was open to subjective interpretation; and

(3) The 2012 changes to the Manual "definition" were substantive rather than clarifying,

—are all errors in the application of Texas Medicaid policy and law.

Moreover, Proposed FoF No. 49 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Administrative Law Judge, as provided by the Executive Commissioner's delegation of authority, has complete discretion to modify it.¹⁰⁷

The ALJ substitutes the following for Proposed Finding of Fact No. 49:

HHSC-OIG presented *prima facie* evidence that is credible, reliable, and verified, and that has indicia of reliability that ADC submitted willful misrepresentations to Texas Medicaid.



50. Proposed FoF No. 50 states: *There is no evidence that is credible, reliable, or verifiable, or that has indicia of reliability, that ADC committed fraud or misrepresentation in filing requests for prior authorization with TMHP for the 63 patients at issue in this case.*

Proposed FoF No. 50 is erroneous, because it ignores the weight of the evidence in this case and it misapplies Texas law and Medicaid policy.

¹⁰⁷ *Id.*

First, the proposed finding misapplies Texas law governing the HHSC-OIG's burden of proof in this case. As noted in CoL No. 12, to maintain the payment hold, HHSC-OIG must only make a *prima facie* showing of evidence that is credible, reliable or verifiable, or that has indicia of reliability that ADC has committed fraud or willful misrepresentations in this case.



The SOAH ALJs' determination that HHSC-OIG presented "no evidence" on this issue ignores the expert testimony of Dr. Tadlock and is fatally tainted by the ALJs' legally erroneous interpretation of Medicaid policy with respect to the definition of ectopic eruption. As noted in these exceptions, the ALJs' determinations that—

(1) Texas Medicaid "defined" ectopic eruption uniquely and differently in the Manual than the generally accepted definition in the orthodontic professions;

(2) Said definition was open to subjective interpretation; and

(3) The 2012 changes to the TMPPM "definition" were substantive rather than clarifying.

—are all errors in the application of Texas Medicaid policy and law.

In addition, Proposed FoF No. 50 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Administrative Law Judge, as provided by the Executive Commissioner's delegation of authority, has complete discretion to modify it.¹⁰⁸

The ALJ substitutes the following for SOAH's Proposed Finding of Fact No. 50:

HHSC-OIG presented *prima facie* evidence that is credible, reliable, and verified, and that has indicia of reliability that ADC committed fraud or willful misrepresentation in filing requests for prior authorization with TMHP for a substantial majority of patients in the OIG audit sample.



Failure to Maintain Records

51. When HHSC-OIG arrived at ADC in November 11, 2012, and asked for 63 case files, *prima facie* evidence exists that ADC could not locate eight dental models, four HLD score sheets, and two pre-treatment x-rays.
52. ADC forwarded the HLD score sheets and supporting documentation to TMHP when ACD filed its requests for prior authorization.
53. HHSC-OIG presented *prima facie* evidence that ADC failed to retain these records and models for the required five years.

¹⁰⁸ *Id.*

54. Proposed FoF No. 54 states: *HHSC- OIG failed to present prima facie evidence that ADC billed or caused claims to be submitted to Texas Medicaid for services or items that are not reimbursable by the Texas Medicaid program.*

Proposed FoF No. 54 is erroneous, because it misapplies Texas law and Medicaid policy.

If the SOAH ALJs had applied the proper standard for ectopic eruption and the uncontroverted expert testimony of Dr. Tadlock to the facts of this case, they would have concluded that, in at least 58 of the 63 cases in the sample, ADC submitted PA requests for patients who were not qualified for full orthodontia.



Furthermore, Proposed FoF No. 54 addresses a mixed question of fact and law, and is a so-called “legislative finding.” Therefore, the Administrative Law Judge, as provided by the Executive Commissioner’s delegation of authority, has complete discretion to modify it.¹⁰⁹

The ALJ substitutes the following for SOAH’s Proposed Finding of Fact No. 54:

HHSC-OIG presented *prima facie* evidence that is credible, reliable, and verified, and that has indicia of reliability that ADC billed or caused claims to be submitted to Texas Medicaid for services or items that are not reimbursable by the Texas Medicaid program.



55. Proposed FoF No. 55 states: *Patient 1, 56, and 60 were eligible for interceptive treatment under Texas Medicaid.*

Proposed FoF No. 55 is erroneous, because it misapplies Texas law and Medicaid policy.


To the extent the SOAH ALJs construed “interceptive” treatment to mean something less than comprehensive orthodontics [procedure code D8080] (and therefore outside the requirement that patients be 12 or older or have no baby teeth), the SOAH ALJs misstate the evidence. ADC billed the procedure code D8080 for these patients, meaning they falsely represented to the state that these patients were 12 or older or had lost all baby teeth. To the extent that SOAH ALJs use “interceptive” to include procedure code D8080,¹¹⁰ they are again in error: procedure code D8080 is explicitly not applicable to patients like these who have baby teeth and are younger than 12 years of age.



These patients may well have been eligible for interceptive treatment—that is, something less than comprehensive orthodontics—but the evidence in this case is clear: ADC billed Medicaid for—and represented to the State that these patients qualified for—procedure code D8080, or comprehensive orthodontics. The fact that ADC billed for comprehensive orthodontics when their patients did not qualify for that treatment patently is a program violation, and warrants a payment hold.

¹⁰⁹ *Id.*

¹¹⁰ See Res. Ex R-15 at § 19.19.7.


 Specially, with regard with Patient 15, the PFD states that ADC requested “prior authorization for interceptive treatment.”¹¹¹ ADC requested prior authorization of procedure code D8080, comprehensive orthodontics, for this patient, even though the patient was 9 years old and had baby teeth.¹¹²

With regard to Patient 56, ADC requested procedure code D8080 comprehensive orthodontics for this patient, even though the patient was 9 year old and had baby teeth.¹¹³

Finally, ADC requested procedure code D8080 comprehensive orthodontics, for Patient 60 as well, even though this patient was under 12 and had baby teeth.¹¹⁴ As before, without more, this is a program violation.¹¹⁵

Additionally, SOAH’s Proposed Finding of Fact No. 55 addresses mixed questions of fact and law, and is a so-called “legislative finding.” Therefore, the Administrative Law Judge, as provided by the Executive Commissioner’s delegation of authority, has complete discretion to modify it.¹¹⁶

The ALJ substitutes the following for SOAH’s Proposed Finding of Fact No. 55:

 **ADC committed program violations when it submitted prior authorization requests and HLD forms for procedure code D8080 comprehensive orthodontic treatment, on Patients 15, 56, and 60 when these patients did not qualify for comprehensive orthodontics.**

56. Proposed FoF No. 56 states: *Program violations range from “very innocuous” to “very important.”*

The PFD offers no examples of which program violations that the SOAH ALJs label “very innocuous” and “very important.” In addition, the PFD cites no legal statutory, regulatory, or clinical basis for these qualitative distinctions and offers no definition or instruction regarding the manner in which to determine the categories into which the program violations might fall. Proposed FoF No. 56 is thus conclusory and essentially meaningless.

The ALJ would delete Proposed Finding of Fact No. 56 as meaningless.

¹¹¹ PFD at 33.

¹¹² Res. Ex. P-15 at P15-0019 (ADC Prior Authorization Request Form for Patient 15 requesting “D8080”).

¹¹³ Res. Ex. P-56 and P56-0015 (ADC Prior Authorization Request Form for Patient 56 requesting “D8080” for a charge for \$775.00.)

¹¹⁴ Res. Ex. P-60 at P60-0004 (ADC Prior Authorization Request Form for Patient 60 requesting “D8080” for a charge of \$775.00.)

¹¹⁵ 1 T.A.C. § 371.1617(1) (K) and (5)(G).

¹¹⁶ *Tex. State Bd. of Dental Examiners v. Brown*, 281 S.W.3d 692 (Tex. App. -- Corpus Christi 2009, pet. denied); *Froemming v. Tex. State Bd. of Dental Examiners*, 380 S.W.3d 787 (Tex. App. -- Austin 2013, no pet.).

57. Proposed FoF No. 57 states: *ADC's violation is a technical violation and based upon this record does not rise to a level of substantive concern.*

Proposed FoF No. 57 is erroneous, because it misapplies Texas law and Medicaid policy.



To the extent this finding rests on the false premise that ADC's record keeping violations are the only actionable violations found by the HHSC-OIG, the SOAH ALJs appear to reason that ADC's program violations, by themselves, do not justify continuation of the payment hold. The underlying premise, in turn, is based on the application by the SOAH ALJs of Texas Medicaid policy regarding ectopic eruption. This finding is also erroneous, because it is within the sound direction of the Executive Commissioner, and not the SOAH ALJs, to determine whether ADC's record keeping violations are cause for concern, or not.



HHSC-OIG based its payment hold, in part, on ADC's failure to provide records pursuant to its request; in some cases, ADC had these records, and entered them in evidence in this case over a year after the Inspector General requested them. ADC's failure to immediately provide these records is a program violation and may result in a payment hold.¹¹⁷



Proposed FoF No. 57 is erroneous in characterizing these program violations as "technical violation[s]" that are not "of substantive concern," particularly in light of the fact that HHSC-OIG is obligated to investigate Medicaid fraud, waste, and abuse, and, in the course of investigating, is entitled to request documents of providers.¹¹⁸ Furthermore, the proposed finding fundamentally misunderstands the vital role that the provider's clinical and administrative documentation plays in maintaining program integrity and establishing the medical necessity of the disputed procedures and services. In fact, the imposition of a payment hold was specifically authorized by the Texas Legislature as a remedy to a provider's refusal to supply HHSC-OIG records upon its request.¹¹⁹



HHSC-OIG is entitled to base payment hold determinations on the records that Medicaid providers submit in response to a proper request. The Legislature concluded that Medicaid providers' failure to provide documents to the HHSC-OIG pursuant to a written request for them is a "substantive concern," particularly in cases, like this one, where the provider later attacks the validity of the payment hold based on the existence of documents it failed to provide to HHSC-OIG. The existence and provision of documents necessary to fully document and evaluate the necessity and delivery of medical services is paramount to the integrity of the Medicaid system.



¹¹⁷ 1 T.A.C. § 371.1617(2)(A); R-14 at § 1.2.3. ("Failure to supply the requested documents and other items, within the time frame specified, may result in a payment hold . . . or exclusion from Medicaid"); Res. Ex. R-15 (2009 TMPPM), § 1.4.3.

¹¹⁸ Res. Ex. R-14 (2008 TMPPM) § 1.2.3; Res. Ex. R-15 (2009 TMPPM) § 1.4.3.

¹¹⁹ See Tex. Gov't Code Ann. § 531.102(g) (2011).

Moreover, Proposed FoF No. 57 addresses the mixed question of fact and law, and is a so-called “legislative finding.” Therefore, the Administrative Law Judge, as provided by the Executive Commissioner’s delegation of authority, has complete discretion to modify it.¹²⁰

The ALJ substitutes the following for SOAH’s Proposed Finding of Fact No. 57:



ADC’s record keeping violations, together with the *prima facie* evidence presented by HHSC-OIG of ADC’s fraud and willful misrepresentations, gives rise to substantial concern regarding ADC’s compliance with Texas Medicaid law and policy.

CONCLUSIONS OF LAW

1. HHSC-OIG has jurisdiction over this case. Tex. Gov’t Code ch. 531; Tex. Hum. Res. Code ch. 32.
2. SOAH has jurisdiction over the hearing process and the preparation and issuance of a proposal for decision, with findings of fact and conclusions of law. Tex. Gov’t Code ch. 2003.
3. Notice of the hearing was properly provided. Tex. Gov’t Code ch. 2001.
4. Proposed CoL No. 4 states: *HHSC-OIG had the burden of proof.*

Proposed CoL No. 4 is erroneous, because it is a misstatement of the law.

The HHSC-OIG is required by law to impose a payment hold “on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or willful misrepresentation under the state Medicaid program in accordance with 42 C.F.R. Section 455.23.”¹²¹ Additionally, “[t]he department shall discontinue the hold 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 and willful misrepresentation.”¹²²

The ALJ substitutes the following for SOAH’s Proposed Conclusion of Law No. 4:

The Inspector General’s burden to maintain the payment hold under section 531.102(g)(2), Texas Government Code, or section 32.0291(c), Texas Human Resources Code, is to show by reliable or *prima facie* evidence that ADC has

¹²⁰ *Tex. State Bd. of Dental Examiners v. Brown*, 281 S.W.3d 692 (Tex. App. -- Corpus Christi 2009, pet. denied); *Froemming v. Tex. State Bd. of Dental Examiners*, 380 S.W.3d 787 (Tex. App. -- Austin 2013, no pet.).

¹²¹ Tex. Gov’t Code Ann. § 531.102(g)(2) (2011).

¹²² Tex. Hum. Res. Code Ann. § 32.0291(c) (emphasis added).

committed fraud or made willful misrepresentations.

5. It is an unlawful act to knowingly make or cause to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized. Tex. Hum. Res. Code § 36,002(1) (2003).
6. The term “knowingly” means that the person has knowledge of the information, acts with conscious indifference to the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. Proof of the person’s specific intent to commit an unlawful act under §36.002 is not required to show that a person acted “knowingly.” Tex. Hum. Res. Code § 36.0011 (2003).
7. “Fraud” is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person, including any act that constitutes fraud under applicable federal or state law. Tex. Gov’t Code§ 531.1011(1) (2011).
8. HHSC-OIG must impose a hold on payment of claims for reimbursement submitted by a provider on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or willful misrepresentation under the state Medicaid program. Tex. Gov’t Code § 531.102(g)(2) (2011).
9. All Medicaid payments to a provider must be suspended after the state Medicaid agency determines that there is a credible allegation of fraud for which an investigation is pending, unless the agency has good cause not to suspend payments (or to suspend payments only in part). If the state’s Medicaid fraud control unit accepts a referral for investigation of the provider, the payment suspension may be continued until such time as the investigation and any associated enforcement proceedings are completed. 42 C.F.R. § 455.23 (2011).
10. Proposed CoL No. 10 states: *“Credible allegation of fraud” is “an allegation, which has been verified by the State, from any source” including, for example, ‘fraud hotline complaints, claims data mining, and provider audits. Allegations are considered 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.’*

Because Proposed CoL No. 10 incorrectly states the law, the Administrative Law Judge, as provided by the Executive Commissioner’s delegation of authority, has complete discretion to modify CoL No. 10 to correctly state the law, add the essential phrases and words of “patterns identified through” and “and law enforcement investigations” and substitute the words “can be” for “is” and “but no limited to” for “for example.”

The ALJ substitutes the following for SOAH's Proposed Conclusion of Law No. 10:

“Credible allegation of fraud” may be “an allegation, which has been verified by the State, from any source” including, but not limited to, ‘fraud hotline complaints, claims data mining, and patterns identified through provider audits, and law enforcement investigations. Allegations are considered credible when they have indicia of reliability and HHSC has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by case basis.’”

11. HHSC-OIG may impose a payment hold on future claims submitted by a provider if there is reliable evidence that the provider has committed fraud or willful misrepresentation regarding a claim for reimbursement under the medical assistance program. Tex. Hum. Res. Code § 32.0291(b)(2003).
12. In a SOAH hearing on a payment hold, HHSC-OIG must make a prima facie showing that the evidence relied upon in imposing the payment hold is relevant, credible, and material to the issue of fraud or willful misrepresentation. Tex. Hum. Res. Code § 32.0291(c) (2003).
13. Proposed CoL No. 13 states: *HHSC-OIG lacks authority to maintain the payment hold against ADC for alleged fraud or misrepresentation.* Tex. Gov't Code §531.102(g) (2011); 42 CFR § 455.23 (2011); Tex. Hum. Res. Code § 32.091 (c) (2003); 1 Tex. Admin Code §§ 371.1703 (b)(3), 371.1617(a)(1)(A)-(C) (2005).

Proposed CoL No. 13 is erroneous, because it misapplies Texas law and Medicaid policy to the facts of this case.

This conclusion rests on the ALJs' misunderstanding of Medicaid's limited orthodontic benefit and their misconstruction of ectopic eruption. Further, this conclusion reflects the ALJs' failure to apply the proper evidentiary burden in this case.

The ALJ substitutes the following for SOAH's Proposed Conclusion of Law No. 13:

HHSC-OIG should maintain the payment hold against ADC for alleged fraud or willful misrepresentation, and program violations. Tex. Gov't Code § 531.102(g) (2011); 42 CFR § 455.23 (2011); Tex. Hum. Res Code § 32.091 (c) (2003); 1 Tex. Admin. Code §§ 371.1703(b)(3), 371.1717(a)(1)(A)-(C), (I), (K), (2)(A), (5)(A), (5)(G) (2005).

14. Proposed CoL No. 14 states: *A payment hold should be reasonably related to the magnitude of the violation.*

Proposed CoL No. 14 is erroneous, because it misstates the law.

The Texas Government Code mandates a payment hold when reliable evidence was presented of fraud or willful misrepresentation.¹²³ Additionally, “[t]he department shall discontinue the hold 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 and/or willful misrepresentation.”¹²⁴

The ALJ substitutes the following for SOAH’s Proposed Conclusion of Law No. 14:

The Texas Government Code mandates a payment hold when reliable evidence has been presented of fraud or willful misrepresentation. Tex. Gov’t Code § 531.102(g)(2). The department shall discontinue the hold 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 willful misrepresentation. Tex. Hum. Res. Code § 32.0291(c).

15. The prima facie evidence established that ADC committed program violations by failing to maintain certain patient records for the required five years. 1 Tex. Admin. Code §§ 371.1703(b)(5),(6); 371.1617(2)(A), (5)(A) and (G)(2005).
16. Proposed CoL No. 16 states: *These technical violations [for failing to maintain certain patient records] are very limited in number and are innocuous; therefore, they do not warrant a payment hold in this case.*

Proposed CoL No. 16 is erroneous because: (1) failure to provide records to HHSC-OIG is itself a program violation; (2) failure to provide records to HHSC-OIG is neither a technical violation nor innocuous. HHSC-OIG decided to impose a payment hold on ADC based on the patient records it provided in response to HHSC-OIG’s written request and based on the fact that ADC failed to provide certain records at that time. The record reflects that these so-called “technical violations” in fact constitute serious violations of Texas Medicaid law.

The ALJ substitutes the following for SOAH’s Proposed Conclusion of Law No. 16:

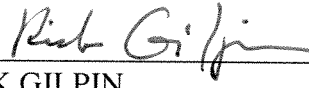
ADC’s failure to immediately provide HHSC-OIG with the documents and other items required in writing is a significant program violation that, along with the extensive and overwhelming pattern of willful misrepresentations in ADC’s HLD score sheets, and ADC’s billing for non-reimbursable services, should result in a continuing payment hold. Tex. Gov’t Code § 531.102(g) (2011); 1 Tex. Code §§ 371.1617 (2)(A) (2005); 2008 TMPPM at § 1.2.3.

The undersigned judge orders that the payment hold continue at 100 percent.

¹²³ Tex. Gov’t Code Ann. § 531.102(g)(2).

¹²⁴ Tex. Hum. Res. Code Ann. § 32.0291(c) (emphasis added).

Entered this 27th day of February, 2014.



RICK GILPIN

Administrative Law Judge

Health and Human Services Commission