

House Committee on Human Services - 19 March 2013

Jack Stick, Deputy Inspector General for Enforcement, OIG Testimony

**Rep. Raymond:** I think, what would be good, members, at this time is to call on Jack Stick, Health and Human Services, Office of the Inspector General. Maybe talk a little bit. I know you don't have a position on this Bill, former representative, a former colleague, but if you state your name for the record, your position and talk a little bit about this.

**Jack Stick:** Mr. Chairman and members, thank you for giving me the chance to be here today. My name is Jack Stick, I'm a Deputy Inspector General of the Health and Human Services Office of Inspector General. Mr. Chairman, as indicated I don't have a position on the Bill but I am here to answer any questions that the Committee members might have.

**Rep. Raymond:** So basically you're okay with the Bill, right?

**Stick:** I don't have a position on the Bill. I'm just from the Government and I'm here to help.

**Rep. Raymond:** Rep. Zerwas.

**Rep. Zerwas:** Thank you Mr. Chairman and thank you Jack for being here. Could you just kind of walk me through this? Let's say I'm a physician, I do a fair amount of Medicaid, you know, 30 percent of my practice is Medicaid. And we perhaps have, something comes up that you all think should be investigated. Can you just walk me through – what's the steps and what would occur as a consequence of your investigation.

**Stick:** Sure. Mr. Chairman I think that's a great question. I think we start with how a case would actually come to the OIG. And we get case referrals from any number of sources. We get them from recipients who call to complain, from other providers who call to complain, we get them through electronic monitoring of billing patterns, aberrations that we would see in those billing patterns, letters – really any source that you can imagine we've probably received a complaint in that manner. The first step that we do is we take a look at the case. We're obligated by law to evaluate every complaint that we receive, and we do that. If we get a call at 3 o'clock in the morning, somebody whispers into a voicemail, you know, 'Dr. Jones is cheating Medicaid, you should look at him', we have to take a look at that case. Now I'll tell you that we will probably put that somewhere down the line and give it consideration at a later date. As compared to a caller who says, you know, 'My name is Dr. John Zerwas, I am an anaesthesiologist, I want to report Dr. Raymond because he's doing A, B, C and D. I've seen this and you can reach me at the following number'. And that's a complaint that we would take much more seriously, provide I think more investigative resources to because it's got initial credence to it. But that alone isn't enough for us to move forward. We'll take a look at a provider's billing history, take a look and see whether or not there's any aberrations that we can find. If there are no aberrations, we close the case at that point and the provider would never really know that we'd even taken a look at him.

If we do find aberrations or something else that suggests we need to take a look further, we draw a statistically valid random sampling of the provider's claim. Actually, even before we do that, we would evaluate the claim on a couple of different levels, so if we didn't see anything we would simply close it. If we saw something more than that, we'd evaluate it and determine whether it was appropriate to move forward to a full scale investigation or we transfer it to a field investigator and pull records, or whether it's something that we could refer to an appropriate regulatory board for simply education. And if we can do that, we do do that.

**Rep. Raymond:** Such as the Medical Board.

**Stick:** Such as the Medical Board or the Dental Board or the Nursing Board. I can get you the exact number but I think we probably refer in the neighborhood of 20 to 25 percent of the complaints that we receive, to appropriate regulatory agencies. We probably close a similar number of cases every year, and then advance the other ones to a full scale investigation. At the full scale stage, the full scale investigator essentially repeats the work we've already done. And that full scale investigator has the authority to refer the case for further investigation, refer it for education to a regulatory agency, to take a look and decide to close the case at that point. As long as there is justification for what we're doing, you know, the field investigator has the authority to do that.

Assuming the case moves forward beyond that point, we'll draw a statistically valid random sampling of the codes we believe are potentially problematic. We'll visit the provider. Serve a records demand letter on the provider. When providers enroll in Medicaid, they sign a contract in which they agree to provide those – first to maintain the records on premises...

**Rep. Raymond:** So at that point you're in my office, is that right?

**Stick:** In your office.

**Rep. Raymond:** Okay.

**Stick:** We'll collect the records. Conduct any interviews that we need to conduct. Bring the records back on... speaking specifically about a medical professional...

**Rep. Raymond:** Correct. I just want to be sure I understand what your typical activity is, in terms of following through on this.

**Stick:** Right. Once we have the records, we'll conduct an initial review of the records, just kind of make sure everything is there. Then we refer the records to a comparable or peer professional -- so a Board-certified anaesthesiologist – would get referred to a Board-certified anaesthesiologist we have on contract, who would then review those medical records and tell us, the billing records, and tell us whether there are issues that we need to be concerned about. Those experts don't make determinations about fraud. They say this is medically necessary or this is medically unnecessary, this is overkill, this is insufficient, whatever happens to be present in the records that that expert will take a look at and let us know. We ask our experts, after a review of a portion of the cases, to give us a, kind of a periodic update, so that we'll know what's going on. If we find

evidence at that point, if the expert reviewer has given us an indication that there are problems with the billing that indicate either that the provider knowingly and intentionally has billed Medicaid for services improperly; has done that type of billing with conscious disregard of the truth or falsity of the claim that the provider submitted; or did it with reckless indifference as to the truth or falsity; we evaluate that for whether or not we need to impose a payment hold based on a credible allegation of fraud.

The credible allegation of fraud is a term created by and required, a compliance with which is required by the Affordable Care Act. It essentially means that we have a verified allegation of that type of behavior that meets one of those three criteria. Verified is, 'verified with reasonable indicia of reliability'. If we find that there is a basis for a payment hold, we'll notify the provider that we are imposing a payment hold. The decision within our office to impose a payment hold is a complicated and complex process. The field investigator has to initiate the process. The field investigator has to get approval from his or her manager. That manager has to approve it and then get approval from his or her division director, which is the division of Medicaid provider integrity, who then has to approve it and refer it to me. I have to review it and approve it. And if I do, we send it over to the Sanctions division which has lawyers who also have the ability to reject the payment hold at that point.

**Rep. Raymond:** So you review all payment holds?

**Stick:** Every one. I would say that I have probably rejected in the neighborhood of 15 percent of the payment hold, maybe 20 percent of the payment hold requests that have come through. Rejecting them for any number of reasons such as unclear or insufficiency of evidence; reject them also based on access to care issues. If there is one provider in a rural setting, even if we suspect that there's something going on, we can't just put him on a payment hold and run the risk of putting that provider out of business. So we also verify access to care issues. Once the provider has received noticed of the payment hold, the provider will receive a letter and that letter will say you're on a payment hold, this is the reason for the payment hold. These are your rights. You have the right to an informal hearing with the Office of Inspector General, and you have the right to a hearing at the State Office of Administrative Hearings. Sets forth the timeline that the provider has to comply with in order to make those requests.

**Rep. Raymond:** So if, say if I had a practice that had 50 percent Medicaid, then any Medicaid patient that I did at that point forward I would not get paid for, and any outstanding claims at that point that hadn't been processed, I wouldn't be paid. That revenue stream would be interrupted immediately and completely, is that correct?

**Stick:** It could be. If there is no access to care issue, and there's no obstruction to putting a payment hold on and we did go ahead and move forward with the payment hold, then yes, some or all of that payment stream would be interrupted. It is not necessarily the case that we would impose a 100 percent payment hold. As a rule, we evaluate the total exposure that the State has in potentially fraudulent claims, or in potential overpayments, and we try to base the payment hold amount as a percentage of the provider's billing on the amount of the potential overpayment. If you owed potentially \$50 million dollars to the State, I'd think you'd probably end up somewhere

in the neighborhood of 100 percent. If you owed \$100 thousand dollars, it conceivably could be substantially less.

**Rep. Raymond:** You mentioned access to care – so if I’m the only anaesthesiologist in the game, let’s say down in the Valley, and all of a sudden I’m in a position where if I do Medicaid patients, I’m not going to get compensated for them, and therefore there wouldn’t be another anaesthesiology provider available. Would that be a case of access where you would say we can’t interrupt this person’s revenue stream because they’re going to be, kind of, in between a rock and a hard place down there if that happens.

**Stick:** Yes, that’s a good example. We would probably still bring you in to talk with you about that. It hasn’t been my experience that providers require 100 percent of their Medicaid revenue stream in order to stay in business. If you were that provider and you came in and you said I need 100 percent and here’s the documentation that I need 100 percent, if you were the sole provider – or even if you weren’t – if there was an access to care issue then, yeah, we would reduce your payment hold accordingly. My experience though has been that we can reduce the payment hold something less than, you know, to zero percent, still meet the State’s needs and the providers’ needs. The Federal government requires that we impose a payment hold once we’ve identified credible allegations of fraud. If we fail to do that within the time period specified by the Affordable Care Act, we run the risk, the real risk, they’ve already done it in other States, that CMS will come along behind us and clawback the money that has been paid from the date of the discovery of the fraud. The exception to that, and there are several, but one of those exceptions is, upon showing a good cause, we can reduce the payment hold amount or eliminate the payment hold. And what you’ve described is an example where we could do that.

**Rep. Zerwas:** So and, I’m sorry Mr. Chairman, I just want to get this foundation here as we hear the testimony and stuff. So you come in and you’ve found that, you know, you’ve looked at the practice and you said, okay, we think you have a problem. Payment withhold for a period of time, and there may or may not be a penalty or monies that need to be paid back at that point, is that, so, are we up to that point now? You can kind of tell me where we go from here.

**Stick:** Sure, I want to distinguish penalty from money that needs to be paid back. I would describe a penalty in much the same way the IRS does. A penalty is, you didn’t pay enough on your taxes or you didn’t file your taxes, so now you owe what you didn’t pay, plus you have a non-filing penalty. We have the ability to assess administrative sanctions in much the same way that the IRS does. We would make the determination whether or not to assess an administrative sanction at a later time. It would be after we identified for certain whether there is an actual overpayment. So, yeah that’s the point that we are right now. So we’ve sent a notice, the providers’ aware of due process rights provided in the statute, and then the provider makes the call what to do. The provider can ask for an informal hearing with the OIG; can ask for a hearing at the State Office of Administrative Hearings; or can ask for both.

**Rep. Zerwas:** So if we move into an informal hearing, how does that process work? I’m familiar with that sort of work at the medical board. How does it work in your office?

**Stick:** The provider and his lawyer, or just the lawyer, can come in and talk with us. We provide them with advanced notice of what the concerns that we have are, so we'll provide them with specific case references so they know what we're looking at so they can respond to us. They have the opportunity to come in and really, Dr. Zerwas, they can ask for anything that they want. They can say 'look, I haven't had a chance to review the specifics that you sent us, but this payment hold is killing us, we've got to get a, you know, some kind of relief. Here's some financial records that you can look at that will demonstrate the harm, can we reschedule the informal and you take a look at this and lift the hold and then we'll come back?' We've done that. We've had providers who come in and argued the case point by point. Some successfully, some not successfully. We've had some do both. But the informal hearing is literally informal. It's an opportunity for them to talk. Its free give and take. They can do really, almost anything they want, make any kind of presentation they want. We have the authority at that point, depending on the facts ascertained in the circumstances, to lift the payment hold entirely or to modify the payment hold.

**Rep. Zerwas:** Okay. So, if we go beyond that, and you say okay, we've determined that there is an excess amount of money that's been paid, and you need to, there's an overpayment. And let's say you determine that, that overpayment is \$20 million dollars in my case, and I come in and negotiate with you in this informal settlement hearing. And you say, 'okay, well, we'll bring you down to \$10 million dollars'. I mean, is that the kind of thing that you can do in an informal hearing? Or are we talking about something, or is it

**Stick:** Yes.

**Rep. Zerwas:** You owe \$10 million, we'll bring you down to \$20 but you'll owe penalties on the \$20, and we'll bring you down to \$10 plus penalties. Tell me what happens there.

**Stick:** So you've actually jumped from one phase, which is the payment hold phase, to the second phase, which is we've completed the full scale investigation, we've extrapolated the amount. We've determined that based on the codes that we looked at, using only those codes as our universe of payments, and extrapolating the error rate or the overpayment rate to that universe, we've arrived at an overpayment, the \$20 million dollars.

**Rep. Zerwas:** So yeah, so stop right there a minute so that I understand the codes. So we're only living in the world of, and by codes you mean specific services that the physician performs. And when you say okay, we're going to, let's say there's 3 of those, and you determine that this is where we think that the overpayments have occurred and we see that your practice is composed of x number of these codes. Do I have that correct?

**Stick:** x number, x dollar value.

**Rep. Zerwas:** Okay. And so from the extrap... from the study that you've looked at and the amount you've determined were overpayments, we're now going to apply that to your entire practice for these 3 codes

**Stick:** Correct.

**Rep. Zerwas:** without looking at all those others.

**Stick:** So in the case that you described, we would have looked at those 3 billing codes, determined that you, in the last 4 years and 10 months, billed \$40 million dollars in those 3 codes. You have a 50 percent overpayment or error rate. There's something wrong with 50 percent. And let's just assume for this conversation, you didn't do the work at all. So that would be a 100 percent recoupment. We will recoup or seek to recoup 50 percent of the total universe of just those codes, so the \$20 million dollars. Alright, then you come in for an informal conference and you talk with us and you said, 'Yeah, I have a computer glitch, we identified it after you guys came. I agree with you, I own \$20 million dollars, but I've got to tell you, there's no way I'll ever be able to pay you \$20 million dollars. I'm 67 years old, I'm only going to be practicing for another 3 years. I can't do it'. At that point, Medicaid and Medicare diverge. Medicare, which would be a situation where CMS is running these kinds of investigations. CMS has the authority to negotiate its own cases, so they would negotiate with a provider and do whatever they wanted. The State's however don't have that authority, at least not yet. So we don't have the luxury of saying, 'Alright Dr. Zerwas, what can you pay?' We have to find a justification for reducing the amount of that \$20 million dollars. It can be an investigative justification, a medical justification, it can be something. Assuming that we can find some way to that end, we work out an arrangement with you, and we arrive at \$10 million dollars. And you say, 'Well, I can pay \$10 million dollars, but it's going to take me 10 years. I agree I'm going to stay in practice another 7 years beyond what I thought I would, so you know, will you let me pay a million dollars a year back'. We will allow you to make a payment plan, you know, for a 10 year period of time.

The Federal law requires that the State of Texas reimburse CMS the full amount of the identified overpayment within one year of discovery or finalization of the overpayment amount. So we're going to owe CMS the full \$10 million dollars, and they will claw that back after a one year period, or actually within, I think, within 30 days after we reach our agreement. However we will, assuming you comply with your agreement, we'll eventually get that money back. In the event that a provider does not pay, goes out of business or dies or something like that happens, we can submit that information to CMS and seek to get the portion of the unpaid amount back, so the amount that they clawed back they would give to us, they would give back to us. The CMS always get its share.

**Rep. Zerwas:** I see. And they get it fairly timely it sounds like.

**Stick:** Yeah, they would

**Rep. Zerwas:** Okay.

**Stick:** They, they've got somebody to hold pay.

**Rep. Zerwas:** So, if we kind of moved up to where we are then in the provisions of this bill – the opportunities for somebody to actually appeal the overpayment, the overpayment in penalty or just overpaying it, whatever the consideration is there. The option there is to plead that before SOAH or before the Commission itself. Is that correct?

**Stick:** Correct. On the overpayment side specifically, they have the right to appeal to OIG itself, which is an independent entity, independent of the Health and Human Services Commission. However, if that's not successful or they don't get the result they want, they can appeal.

**Rep. Zerwas:** They can appeal?

**Stick:** Yes.

**Rep. Zerwas:** So okay. So you all are the one who decided when everything's not right, and pose what would be this clawback and everything else, but they would be coming to you?

**Stick:** We, no, we would send a notice of potential overpayment. 'Dr. Zerwas, we've identified this \$20 million dollars. You have the right to request an informal and request an appeals process or exercise your right to the appeals process either at HHSC appeals or SOAH'. You come to us, so your first step would be coming to us, you don't have to but I would think most people would want to, and say, 'You're wrong. Here's why you're wrong'. We, you know, you get a copy of the spreadsheet that details each and every instance where we found there's an error, you see exactly what the errors are, you have the opportunity to have your experts, any one or any number of them, go through the same records and identify where we are incorrect. We'll take that information, show it to our experts and say if this were true, you know, does that affect your judgement at all? And we've had experts on contract to us who say yeah, okay, if that squiggly mark on every one of these records means, you know, I did this, well then yeah, an overpayment amount based on that. We've also had people say your expert doesn't know how to read the record, this is what that means. And the experts have said, 'Actually I do know how to read these records, I use the same system in my office and that's not what it means'. But we have the flexibility of that informal for quite a bit of give and take. If that informal is not successful, then the provider has the opportunity to appeal it to HHSC appeals or avail themselves of a transfer to SOAH upon good cause. Good cause could really be anything.

**Rep. Zerwas:** Okay, it could go either way,

**Stick:** Absolutely.

**Rep. Zerwas:** on that point. Okay.

**Stick:** And we don't, we don't, we've not run into this situation because I think it's important to know that we have 110 providers. Let me give another statistic. There are, I think about 80 thousand providers enrolled in Medicaid in the State of Texas, about 59 thousand of them are actively billing. Again, limiting this to just the medical profession, of those 59 thousand, about 12 thousand are either physicians or physician practice groups. Of those 12 thousand, we have 76 cases open on doctors in the State of Texas. Of those 76 investigations, we have 3, OIG has 3 providers on hold. Of the 3 providers on payment hold for credible allegations of fraud, one is a large paediatric practice in the Travis county area, its' been in the news quite a bit; one was a provider in the Valley who died and his practice continued billing; and the third is a doctor in a different part of the State. So we're really talking, if you can pick out the one physician who died and his practice continued billing, we're really talking about two physicians or physician practice

groups out of 12 thousand. So, of the, we have 110 providers on payment hold in the State of Texas right now. Of those 110, one has availed themselves of any type of a hearing, so I can't tell you what would happen if somebody actually went to HHSC appeals or went to HHSC appeals and asked for a transfer. All I can tell you is we don't oppose transfers to SOAH, it doesn't really matter to us where the opportunity exists for a provider to get a hearing on the substantive facts of the overpayment.

**Rep. Zerwas:** The trial de novo has, I think, is provided for in this Bill. What would be, I think, is a fiscal note, noted in here in this Bill – in terms of your organization, to what extent is the financial impact of that.

**Stick:** There is a significant fiscal impact. When you go to a trial, I mean, based on 12 years of litigation I can tell you that going to a trial is about double the amount of work or being in trial is about double the amount of work as getting to trial. So we estimated that we would need additional resources for investigators to continue investigating cases – you have to find additional witnesses, you have to prepare witnesses, you have to do all the things that you can imagine would be attendant to trial. All of that exists at a SOAH hearing, we expect that we would need to do that. The trial de novo would re-create all of that work a second time. All the depositions that existed at the SOAH proceeding would need to be redone. All of the witness preparation, all of the work itself would need to be redone, and then the trial itself would be redone.

**Rep. Zerwas:** Great. Thank you again. Mr. Chairman thank you. I'm sorry to have taken so long to get that basis.

**Rep. Raymond:** Not at all. We'll call on you again. Jack, let me ask you, by now, what are you finding at least – I know you won't know the exact number – but when you're looking at someone and you say, well it looks like we've got a case here, we've got something we've got to look at here, right. You start looking at it and you withhold payment, etc. what, can you put a percentage on the claims that you've looked at, that your agency is looking at, that you think are not good claims, bad claims – hold on – that have prior authorization.

**Stick:** Sure. When you look at prior authorization, you're looking at certain specified types of services. So for example...

**Rep. Raymond:** Let's just look at those. Let's look at those.

**Stick:** Okay. So in the orthodontia area, we had cases with error rates or potential overpayment rates, as low as 30, 30 or 39 percent, we've had them as high as 100 percent. There is a cluster, a significant cluster in the 85 and above range.

**Rep. Raymond:** So you're saying that most of the, alright so, again can you put a percentage overall on the ones that you're looking at that you think are bad, that had prior authorization by the agency?

**Stick:** I mean, I could tell you... I can't give you a specific number, but I can say, if you basically averaged it, it would be over 90 percent of the orthodontic claims were bad.



**Rep. Raymond:** Okay. But they were authorized.

**Stick:** Yes Sir.

**Rep. Raymond:** Right?

**Stick:** Yes Sir.

**Rep. Raymond:** Alright. So why don't you just explain that a little bit for the Committee what that means, prior authorization.

**Stick:** In the area of orthodontics, and it's important to note that there are other areas that require, that require prior authorization, but we'll talk about orthodontics for now and if you have any questions about others I'll try to answer those. The orthodontists require to establish – the Medicaid in Texas does not pay for cosmetic correction of orthodontia, it only pays for a handicapping malocclusion. In other words, the child or the Medicaid recipient has to have a fairly significant problem with their bite. That handicapping malocclusion can be determined in one of two ways. One way, the easiest way, would be for the orthodontist to write a letter and simply say, 'this is what I see, this is the medical justification, the dental justification for braces, notwithstanding any other rule, in my opinion, my dental or medical opinion, this child needs orthodontia'. And TMHP could approve that child. To my knowledge, TMHP didn't get any letters like that and approve anybody like that. If they did, it was ...

**Rep. Raymond:** They could have.

**Stick:** I'm sorry?

**Rep. Raymond:** You said they could have.

**Stick:** Yeah, I'm not aware that any claims were approved for that reason. The second way, and by far the most common way, is for the orthodontist to complete a handicapping labio-lingual deviation score sheet, an HLD score sheet. The HLD score sheet essentially lists out a number, it's just a grid where the orthodontist will calculate everything that is wrong in a recipients' mouth. And each thing, and each occurrence of thing gets a numerical score attached to it. So something might have a score of 2 and if you had 3 of those things, you'd get a 6. You total up the total number of points on the HLD score sheet, and if they reach the level of 26 or above, then we have said, or TMHP has said, by definition that is a handicapping malocclusion. 26 or above means that there is a reason for Medicaid to pay for braces. So a, an orthodontist would then fill out this HLD score sheet for every Medicaid recipient who needed or wanted braces, calculate the HLD score submitted to TMHP. TMHP would then review it and either approve or deny the claim.

**Rep. Raymond:** Okay. Let's talk about real quickly, the informal hearing you mentioned, that anybody could ask for an informal hearing, right, and i guess, often do.

**Stick:** They do.

**Rep. Raymond:** Okay, now, once you've had an informal hearing, does that affect the formal hearing in any way? Or you have an informal hearing and you, they come in, they tell you what they think, and you know, it's kind of like a discussion, you know, informal discussion. You mentioned a while ago, sometimes they'll walk away, maybe often times walk away not satisfied. So then the next, what happens after that? Most of them are not satisfied with the informal hearing. Let's just say the provider is not satisfied with the informal hearing, so then, is there a formal hearing after that?

**Stick:** There can be. There can be another informal hearing if they want. If they're not satisfied the first time, they can go away, they can get more evidence, they can hear what our concerns are, they can come back for a second or third informal hearing. We're willing to have as many as are productive. But assuming we've reached the end of that informal route, they can request that the hearing be docketed – this is on the payment hold – they can request that it be docketed at the State Office of Administrative Hearings. On the overpayment itself, they can request that it be docketed at HHSC appeals or have it transferred to SOAH.

**Rep. Raymond:** And so this Bill is seeking to allow on the overpayment, the payment hold, to go to SOAH.

**Stick:** Right.

**Rep. Raymond:** Right?

**Stick:** That's my understanding.

**Rep. Raymond:** So that would make it, if this Bill passes, then both the overpayment and the payment hold would both go to SOAH. Right now only one.

**Stick:** Yes Sir.

**Rep. Raymond:** Is that correct?

**Stick:** That's correct.

**Rep. Raymond:** Do you know why that is? Why we've been inconsistent that you have it for one and not the other?

**Stick:** I don't.

**Rep. Raymond:** But on your end, the State's end, you can request SOAH either way. Is that right?

**Stick:** The provider has the discretion. Okay, so if the provider wants to go to SOAH under the existing rules, the provider can file a motion to transfer it to SOAH.

**Rep. Raymond:** Well, what is this Bill trying to do then, let's see, I thought we're trying to do something that's not being done now? It says, I'll read the Bill and announce it to you. Let's see. This Bill amends government codes entitled a Medicaid provider from whom Health and Human Services Commission or Inspector General seeks to recover an overpayment made to the provider under the Medicaid program to a hearing on the determination made or other action taken by the Office to recover their repayment. The Bill specifies that such a hearing in a contested case under the Administrative Procedure Act and requires the State Office of Administrative Hearings to conduct a hearing, and after the hearing, to make a final determination on the matter. So, I'm sorry, I guess I'm a little confused. Maybe we'll have to get the author back up here. Well, what is this Bill seeking to change that doesn't happen now?

**Stick:** As I see it, Mr. Chairman, this would do two things that aren't extant in the law today. The first one is that it would require the case to be sent to SOAH and not allow the opportunity to send it to HHSC appeals. The second thing that it would do, is it would invest in SOAH the final decision-making authority. Currently, the Executive Commissioner signs a PFD, a proposed final decision, authored by a SOAH judge or an administrative law judge in the HHSC appeals division. So it would change that aspect as well.

**Rep. Raymond:** Okay. Talk to me a little bit about, talk to us a little bit about the statistically valid samples. Who came up with the word 'statistically valid'?

**Stick:** Who came up with it? I don't know.

**Rep. Raymond:** Is that, is that the State saying this is, we've determined this is statistically valid. we're looking at thousands of claims, we're going to put... there are thousands of claims, we're going to look at about 50 of them, and whatever that says, we'll then apply that to the thousand.

**Stick:** Mr. Chairman, I'm going to give you an answer and I'm going to preface it with this caveat – my last statistics class was about 23 years ago, So

**Rep. Raymond:** That's what makes me nervous.  
[laughing]

**Stick:** Okay. Fortunately, fortunately OIG employees or actuaries or statisticians who handle the complicated math for me. They use a

**Rep. Raymond:** Would you rather have one of them come up?

**Stick:** Previously – they're not here – they used a previously established sample, tool, a sampling tool.

**Rep. Raymond:** Previously established by whom?

**Stick:** Ah, I think we drew upon a tool approved by the Controller of Public Accounts. It's a tool that we didn't just devise ourselves. It's based on approved Federal

**Rep. Raymond:** How far back we going now? Bullock?

**Stick:** No, I think I would say

**Rep. Raymond:** Straighthorn?

**Stick:** Probably this controller. I think it was, well OIG was created in 2004, so it would have to be post-2004.

**Rep. Raymond:** Alright.

**Stick:** That sampling tool identifies which cases by striating the available case data. So what it looks at is the number of years we're looking at and the number of cases in a year; the types of cases in a year; the types of codes; the frequency of the codes; the dollar value of the codes – I mean it encompasses everything. All that gets plugged into the formula, and a formula will spit out you need x number of cases. It might be 60 cases, it might be 90 cases. It might be even more. But you need them from this area. So you need this case because this case is in this first area that the tool has identified as a selected area. And then it might go to selected area number 2 and say that you need the 5<sup>th</sup> case here not the 4<sup>th</sup> case, which is what you got the first time, and so on. So it specifically highlights patient names or recipient names based on all of the factors considered. And the factors considered are designed to obtain a statistically valid, random sampling of patient, patient type, code type and all of that. Again, restricted only by the codes that we are looking at. So again, in Dr. Zerwas' example, if we're looking at 3 codes, the valid sample, everybody in that statistically valid random sample is going to have one of those codes – one, two or three of those codes. We will then pull those files from the provider and begin our review, our expert review based on those files and only those files.

**Rep. Raymond:** Well, let me ask you ask you something. So have you looked at one of your bigger cases, let's just say, I'll describe as one of the bigger ones – how many claims would you, would be in question? A thousand? 2 thousand? 5 thousand? 10 thousand?

**Stick:** Ah, how many claims. Ah, I don't know. I would say as many as 20 thousand possibly.

**Rep. Raymond:** So 20 thousand.

**Stick:** 10 thousand.

**Rep. Raymond:** Okay so 20 thousand. How many cases are you all actually looking at of those 20 thousand?

**Stick:** Well, it's... I think, I mean we can get you a more specific answer Mr. Chairman.

**Rep. Raymond:** Get as close as you can get.

**Stick:** Because I don't want to mislead you, and I'll follow up,

**Rep. Raymond:** You'll have some idea.

**Stick:** But I think that the answer is the number of cases that we pull is not really directly related to the number of cases in the universe.

**Rep. Raymond:** Okay. So if you've got 20 thousand cases, can you tell me roughly how many you have to look at to come up with a statistically valid sample.

**Stick:** Let me answer it this way, irrespective of the number of cases in the universe, I think we normally pull in the neighborhood of 80 to 85 cases. Sometimes it would be fewer, sometimes

**Rep. Raymond:** Okay, okay so if you have a thousand cases, you look at 80 to 85 and that's, from that you draw your statistically valid sample, right?

**Stick:** Ah, no, the 80 to 85 would be the statistically valid random sample.

**Rep. Raymond:** Okay, that's your sample. And if you have 10 thousand cases, same thing, or 20 thousand.

**Stick:** Roughly. It would be somewhere in that neighborhood, yes.

**Rep. Raymond:** And so then if you've got, if you've determined, make it a determination in that sample, as you were talking a while ago with Dr. Zerwas, you determined that 50 percent of them were bad. That is, that they were claims that shouldn't have been paid, right?

**Stick:** Correct.

**Rep. Raymond:** Do you then apply that 50 percent to that 20 thousand? So that's 10 thousand of them were bad?

**Stick:** Ah, if the 20 thousand were the universe. So,

**Rep. Raymond:** Right.

**Stick:** the codes that we're looking at are 20 thousand cases, and we establish that there is a 50 percent error rate,

**Rep. Raymond:** Right.

**Stick:** then, and if they're, 100 percent recoupment. So it's not, you billed \$100 dollars and you should've billed \$50 dollars or \$90 dollars, which would be a situation where we'd only seek to recover the delta there between what you billed and what you should have billed. So assume that it's a 100 percent error, then yes, we would say that of the 20 thousand we can statistically expect with statistical certainty, we would expect that half of those claims would represent the same kind of errors that we saw in the sample. And then we would extrapolate to that.

**Rep. Raymond:** I can't speak for others, but that's the stuff that really bothers me or concerns me, because you know, I'm sure statistics are good, you know, they need to be used one way or another. But when you're looking at something like that, you say I got 20 thousand cases, we've looked at 80 of them and we think that 50 percent of these are bad, so 10 thousand of those we shouldn't have paid you. We want that money back. Well, practically speaking, that just bothers me. Maybe it doesn't bother anybody else up here. But importantly, let's just say it's a perfect system in terms of determining, in your view, whether or not we've got a real case here, right? So, we start looking at that. Now, I think what representative Guerra is trying to get to and certainly what I would want to get to, is that we, that we get to the bottom of it as quickly as possible. Because number one, the State is entitled to something, and we want to find out as quick as we can. And number two, if you're wrong, 'cause you might be wrong. I know that, you know, you just might be wrong, maybe they really weren't overpaid that much, and maybe you shouldn't be withholding a lot of money, enough to put somebody out of business. Or as Dr. Zerwas said at that point they take patients, right, you're not paying them, you're withholding payment. Well, there's no business that can go that long, you know, without getting paid. And again, if they're in the wrong, indict them, send them to jail. I mean, I've got no pity for those guys. but I think what Representative Guerra is trying to get to is, something where it would benefit the State to get to the bottom of it as quickly as possible and certainly it would be fair to that doctor, to that provider, to that person, to find out, you know, if they're in the wrong or if your office didn't quite get it right on that one. You get that that's where he's trying to get to with this Bill?

**Stick:** Mr. Chairman, I understand what you're saying. First let me address your concern about the statistics.

**Rep. Raymond:** Well no, first I would like for you to address the part whether you agree that it would be good for the State and certainly fair for the private individual, the person in the private sector out there, for us to get to the bottom of whether there's something wrong here.

**Stick:** Oh without question.

**Rep. Raymond:** As quickly as possible.

**Stick:** Unquestionably. Mr. Chairman I can tell you that we – in 2011 we had cases that were 10 years old and it was taking OIG an average of 46 to 48 months to complete a case investigation. And I think that is, I don't understand that. I can't imagine how that happened or why that happened, and I think it's an intolerable situation. I know the Inspector General doesn't think that it's an acceptable situation for either the State or the providers. Today our new cases are completed in an average of 10 to 16 weeks. We're trying to get that down to a target of 8 weeks. Because we believe that the providers need some certainty about their cases. We're not at that point yet but we're heading down toward that level. So I think a rapid resolution of these cases assists everybody. Let me tell you what can slow that down. One thing that can slow it down is our expert reviews. If we don't get, in orthodontia for example, if we had 50 cases that we're looking at and we've got to get 50 cases reviewed, each review might take 4 to 6 to 8 weeks. So we, you can do the math there. We need to get a lot of orthodontists, board certified orthodontists, to take a look at these cases and it's difficult to do. So that might be one thing that slows it down. The second thing that might slow it down is we needed to retrain our investigators, we needed to

teach them how to move quickly; how to get accurate information; and how to move cases from the left side of the desk to the right side of the desk, in an, you know, expeditious way. Another thing that might slow it down, Mr. Chairman, is that when a provider comes in for an informal review, they have the opportunity, and in fact we want them to tell us where we're wrong. We're not playing a game of financial gotcha, we don't want that. What we want is an accurate, fair and just result. So when the provider comes in and says hey look, I think you maybe didn't consider these things or I found this additional evidence that you might want to take a look at, they give it to us and we'll take it and we'll have that evidence reviewed by the expert again and that might cause a delay.

**Rep. Raymond:** Well but they start, in my opinion, behind the 8-ball man, because again you're looking at 20 thousand claims you say, and 80 of these claims tell us that 50 percent of those 20 thousand are bad. Now you're there, you're, how do you get out of that hole?

**Stick:** Well, a couple of things.

**Rep. Raymond:** Have you allowed them to come up with some kind of a statistically valid sample on their sides?

**Stick:** They're free to do anything they want to do. It will take care of, we'll take in and consider any kind of evidence they want to present.

**Rep. Raymond:** Okay.

**Stick:** You know I understand what you're saying about this statistically valid random sampling. All I can tell you is, its' been approved by Federal courts, its' been approved by State courts, it is an accepted method, an accepted science, and the people who are a lot brighter than I am in this area will tell you why it is, and I can get you a paper that will explain it probably better than I can. All I can tell you is I'm satisfied that the cases that we take a look at, accurately depict the entirety of the universe that we're looking at, only that universe, but that universe. Now, if we are wrong, Mr. Chairman, anybody can prove that. Anybody can demonstrate that our experts are inaccurate, that the methodology is flawed. We will look at that in an informal process, they can introduce that type of evidence at the formal hearings. Again, Mr. Chairman, to date, I've been there for about 22 months, and nobody has challenged that.

**Rep. Raymond:** Okay. What... Members, do you have any other questions right now? Mr. Fallon.

**Rep. Fallon:** Thank you Sir. Help me understand, I'm just trying to work things out here. Take orthodontics for instance, when you notify an orthodontist that you're going to be taking a look at their books, what percentage – and this is actual, factual stuff that's happened, that's what I'd really like to talk about – what percentage would you say do their billings, are their billings affected the next month, do they go down, do they go up, once you let them know that hey, we're going to take a look at you guys.

**Stick:** I cannot think of an example right now, where we have visited a provider, taken records and the provider's Medicaid billings the following month have not decreased. I can't think of an example. I'll go back to verify that. It would be a difficult task, but...

**Rep. Fallon:** So 100 percent. Everybody.

**Stick:** If it's not a hundred percent, it's very close.

**Rep. Fallon:** Okay. When you do go and ask for the records, can they tell you no?

**Stick:** They can tell us no. They have signed a contract that requires that they provide us with the records. If they refuse to provide us with the records, we can put them on a payment hold for failing to do that.

**Rep. Fallon:** You can do that immediately if they refuse...?

**Stick:** We don't do it immediately. We give them a couple of chances. We explain to them what we're doing. We explain it and what authority we have to do this, and what the consequences will be if they don't. But if they persist and some have persisted, we do put them on a payment hold.

**Rep. Fallon:** Okay. Now if I'm crooked, pardon the pun I guess, we're talking about orthodontists, but – I didn't even know I set myself up for that – why would I give you the records? That's the only thing that would prove my guilt.

**Stick:** Right. That would simply brace our case.

**Rep. Fallon:** And you said there was about 59 thousand providers that are taking Medicaid. There's 110 on hold. So statistically that would tell me that 99.8 percent are acting above board.

**Stick:** Yes Sir.

**Rep. Fallon:** You think that's accurate?

**Stick:** Yes Sir.

**Rep. Fallon:** You think that 99.8 percent of Medicaid providers are honest?

**Stick:** I think the overwhelming majority of Medicaid providers are honest. I think that OIG, until very recently, did not sufficiently enforce existing rules, and so I think that there may be an aberration where a few more providers have made mistakes and haven't been caught for a while.

**Rep. Fallon:** What was the latest data that you have as far as recouping costs for fraud, for overbilling?

**Stick:** In terms of dollars?



**Rep. Fallon:** yeah, dollar figures.

**Stick:** So in 2011, OIG identified \$28 million dollars in overpayments. Between fiscal year 2011 and the end of fiscal year 2012, we changed our processees considerably – that by the way, that \$28 million was based on completing 12 cases in a fiscal year – so we changed our processees, we reallocated resources. In fiscal year 12, we were able to increase the number of cases we completed to 108, and increased the dollar value of potentially identified overpayments to \$531 million.

**Rep. Fallon:** So 108 cases, 108 providers ripped the State off a half a billion dollars?

**Stick:** Representative, I wouldn't say ripped the State off. I think some people are actively committing intentional fraud. I think some people are erroneously billing and aren't guilty of an intentional, or even a reckless act, I think they just don't know any better. But between those two extremes, you know, we've identified potentially \$530 million dollars. We've not finalized the overpayment because a lot of those are still in the informal stage.

**Rep. Fallon:** So there's more waste than there is fraud here. You add them up and it's over half a billion dollars.

**Stick:** Yes Sir.

**Rep. Fallon:** Wow.

**Stick:** That's what we're able to identify in fiscal year 12.

**Rep. Fallon:** How many investigative agents do you have?

**Stick:** Assigned to Medicaid? The entire Medicaid Provider Integrity Unit has about 93 people assigned to it. If you take out management and administrative support, I think we have about 52, 53 field investigators.

**Rep. Fallon:** In your opinion if you had more field agents, would that number of \$530 million go up?

**Stick:** I think two things would happen Representative. The first thing I think would happen is the number would go up. The second thing, which is equally important, is the period of time between the overbilling, discovery of the overbilling and resolution of the overbilling, would dramatically decrease. You know, I was a prosecutor for 10 years and what I have found is that a lot of people don't save money. And if somebody is intentionally overbilling the system, then they're certainly not saving their money. The sooner we can find an overpayment, the sooner we can stop that overpayment. The sooner we can say, hey look, you know, we're noticing this spike, this is impermissible, here's why it's impermissible. Don't do it again. And then we don't run into a situation where you know, an orthodontic practice has overbilled the State \$50 million dollars. We would probably have caught that at \$100 thousand dollars.

**Rep. Fallon:** Thank you.

**Stick:** Sir.

**Rep. Raymond:** Any other questions right now Members? Vice-chair Gonzales.

**Rep. Gonzales:** Thank you. Let's take a step back. I want to make sure I understood your testimony correctly. So you said that, you know, these individuals have a chance to protest the decision based on overpayment. Is that correct?

**Stick:** Yes.

**Rep. Gonzales:** and 9 times out of 10 they don't.

**Stick:** On the overpayment, no I'd say almost 100 percent of the time they file a request for both an informal hearing with OIG and a SOAH hearing, or I'm sorry, an HHSC appeals or SOAH hearing. Almost 100 percent of the time. We've done a lot of informals. However of the 110 payment hold letters we have sent out, only one provider has gone to a SOAH hearing.

**Rep. Gonzales:** Okay. Have there been cases where the individuals have been found to be, you know, not guilty is the term I can think of. They were not in any way, shape or form, either billing erroneously or not engaging in fraudulent conduct.

**Stick:** We had one case. The one case that did go to a SOAH hearing where the administrative judge at SOAH determined that the witness we used was not credible because as an orthodontist he did not take Medicaid. And because he didn't take Medicaid, he didn't necessarily understand the type of practice that existed in Medicaid. So she determined that there was not a credible allegation of fraud, but did support the State's position that the provider should still be on a payment hold. So that was sort of splitting the baby -- the payment hold based on program violations. So although there is no basis in that PFD, which the Executive Commissioner did sign, [inaudible] for determining a credible allegation of fraud, the administrative law judge determined that the State still should maintain a payment hold and reduce the amount of the payment hold.

**Rep. Gonzales:** Now, in a case like that, what sort of remedies would that doctor, that organization, have to, what remedies are available against the, against OIG?

**Stick:** Sure. So there are two issues at stake in that case, or in any case similarly situated. Question number one is, is there a credible allegation of fraud. Or, in that case, as in most cases, we also plead not just a credible allegation of fraud, but also a program violation. So in that case although there is no credible allegation of fraud, there is still evidence to support a program violation. That ends that process. If the administrative judge says I find that there is a basis to support the payment hold in whatever amount. That ends that process. The provider could then appeal that decision, after its' been signed, to district court. Secondly, there is the overall issue of an overpayment, whether any overpayment exists. And the provider has the right to come talk with us and negotiate a case, explain where we're wrong, where we've made a mistake, or then take it to a second formal hearing on the issue of whether an overpayment exists. And then from

that point, once the decision has been made, if the provider disagrees with that decision, can appeal that to district court as well.

**Rep. Gonzales:** Alright, thank you.

**Rep. Raymond:** Members, any other questions right now? Stick around?

**Stick:** I'll stay.

(Chairman calls next witnesses, Tony Canales and Fread Houston)

**Rep. Raymond:** Mr. Stick, should we call you up now?

**Stick:** Whatever you like, Sir.

**Rep. Raymond:** Why don't you, let's just, for a couple of questions, Mr. Canales made some very strong assertions here and so did Mr. Houston here. Why don't you state your name for the record again.

**Stick:** Again, my name is Jack Stick, I'm the Deputy Inspector General for Enforcement at OIG.

**Rep. Raymond:** So the biggest, you know, again a big part of the issue here – and Mr. Canales talks about it, what he and Mr. Houston are trying to address – is whether or not, I guess I was scratching the surface when I asked you about your models and you know, whether you could have 20,000 claims and take 62 or [6]3 files and from that make a determination that somebody needs to pay you, the agency back, you know, \$2 or \$3 million or however many million. A bunch of money. And that concerned me. While listening to Mr. Canales it concerns me even more. But you know, again you mentioned you've been a prosecutor, you're an attorney, you understand due process and the concept of due process, so I think Mr. Guerra's trying to get to that, that you're looking at taking a significant amount of property. A State agency makes a determination – hey, we think that you owe us a million, 2 million, 3 million, whatever, and you're not going to go to district court, you ain't going to court guy, to go plead your case. I've got my experts here, the guy that came up with the, what is the word again, I'll get it right, I quoted you, the statistically valid sample, that's been approved by the Federal government, which in this legislation doesn't go real far these days, but nonetheless, that's what you said. But you see the concern, right Jack?

**Stick:** Representative, I do. And I appreciate the opportunity to clarify. Mr. Canales is an outstanding litigator and he's a terrific advocate. And I want to be clear that this is not something that I am doing. This is not Jack Stick's war against orthodontists.

**Rep. Raymond:** Absolutely.

**Stick:** And the extent to which Mr. Canales would hang what OIG does on me, I hope that my reputation, whatever it is, doesn't reflect poorly on OIG.

**Rep. Raymond:** No, I think, back up. I think he was talking about the office. I don't think it was just you.

**Stick:** Okay.

**Rep. Raymond:** I think it's the whole office.

**Stick:** But Mr. Canales said a number of things and I tried to keep up with him in my notes, but he indicated, for example, that there was no place for him to challenge statistics. And again, Mr. Chairman, I don't care whether these hearings are at SOAH or at HHSC Appeals or anywhere else. It's whatever the legislature decides, that's what we'll do. I'm simply acting as a resource here and I want you to understand that there is a process for him to challenge those statistics and he mentioned it, the Daubert Challenge. It's a Federal case that clearly delineates when an expert witness in his testimony can be admitted. And what Mr. Canales correctly pointed out was an error that I made when I said that no one has ever challenged the statistics. Mr. Canales pointed out that one person did, and it was him, and he's absolutely right, and he won. He won at OIG. Because he said to us, he was able to demonstrate that because certain things had happened to the sample, that the sample was no longer valid. He said even using your own methodology it can't be sustained. He was absolutely right Mr. Chairman and we dismissed that part of the case. So, to the extent that he's concerned as an advocate for his client, that there's no place to challenge the fact that he indicate ...

**Rep. Raymond:** Hold on. But I think part of the point that's being made with this legislation, is that right now your office is the judge and the jury.

**Stick:** Mr. Chairman, with all due respect,

**Rep. Raymond:** and the prosecutor.

**Stick:** With all due respect, I think it's more accurate to say that this office investigates claims, prosecutes those claims, in a neutral forum, whether than forum is the State Office of Administrative Hearings or the HHSC Appeals Division which is a completely separate division of a completely separate agency located in a completely different place. Mr. Chairman, if the legislature determines that it's appropriate to have these overpayment hearings at SOAH, so be it. It really won't affect the nature, the type, the scope of the prosecutions that we pursue.

**Rep. Raymond:** That, and in part. So getting back to something else you mentioned, this fiscal note. Somebody in your shop, I don't know, maybe it wasn't you, but somebody in your shop working with, you know, the Controllers Office and LBB, they come up and said well, if this Bill passes, we need another \$1.9 million dollars. But you just said 10 seconds ago, that if we pass this it really wouldn't change your process.

**Stick:** Mr. Chairman, what I said was that if the process were located for overpayments at SOAH as opposed to HHSC Appeals, it really wouldn't affect us at all. And we'll litigate the same case in the same place. It's the de novo trial, based on my reading of the fiscal note, that creates the

additional burden, the work burden, for OIG and for the State Office of Administrative Hearings. What ...

**Rep. Raymond:** Because?

**Stick:** There are, because you'd essentially be replicating the hearing a second time. Whatever the costs are associated or attendant with that first hearing, you would double them because there would be two independent hearings, completely separate and devoid of any connection. But one thing that I do think is important to note, Mr. Chairman, is that Mr. Canales indicated that there is an impartiality that exists within the Health and Human Services Commission by having the appeals heard at the Appeals Division. Again, whatever the legislature decides and whatever the public perception is, I, you know, is what it is. But I do think it's important to note that in the one case that has been litigated, that SOAH opinion went to an HHSC Appeals division judge, where the Office of the Inspector General requested a modification and the ALJ has the authority to modify that opinion. And the ALJ completely poured OIG out, signed the PFD exactly as it was issued by SOAH.

**Rep. Raymond:** But can you, but can you understand the concept that, certainly it bothers me, that a State agency can just, that we're giving a State agency the authority to bankrupt businesses. To bankrupt people who are, you know, are doctors, let's just say doctors, and without ever having to go to, without having your day in court. Can you do that? Do you understand that concept and the concern there?

**Stick:** Mr. Chairman, I understand your

**Rep. Raymond:** Let me back up. Or do you think we should have TCQ or we should have other agencies be able to do what you're doing, and that is, you know, put people out of business, without going to trial, without going to court, without having their day in court.

**Stick:** Well Mr. Chairman, with respect Sir, I think that your question kind of presupposes the answer. If, if ...

**Rep. Raymond:** No, no, no. If you really think it, no it doesn't. If you believe, Jack, that it, in your opinion, that hey, it's ok if a State agency can charge somebody 2, 3, 5 million dollars, and that person does not have the right to go to court, to get in front of a jury and a judge, right? If it's your opinion that that's okay, it's okay to say that.

**Stick:** Well, Mr. Chairman, I'm not charging, in an investigation, anybody anything. We're identifying an overpayment. It was money that the State of Texas never should have paid in the first place, and the

**Rep. Raymond:** Based on a small sample.

**Stick:** Mr. Chairman, even the 9<sup>th</sup> Circuit Court of Appeals, widely regarded as the most liberal circuit in the country, has approved the statistically valid random sampling methodology used by our statisticians. And I'd be happy to send you all of the cases that have descended on me from the

cloud over the last 15 or 20 minutes, and allow you the opportunity to review them or have counsel review them. But what I want to emphasize, Sir, is that we're not just pulling some methodology out of the blue and applying it in a way that is designed to get money back. And we don't get any bonus points for getting more cases or fewer cases, we're just simply applying the law. The methodology that we're using has been approved by a number of district courts by a number of

**Rep. Raymond:** And yet you acknowledge that the one time you were challenged, your methodology was challenged, it was flawed. I think you just said that.

**Stick:** Well, yeah, but I think the question again, presupposes the answer. In the one occasion when our methodology – our methodology wasn't flawed, but the ingredients that went into it, the sample itself, because we had removed claims from that sample, it was no longer a valid sample. Mr. Canales caught it and pointed it out. It was no longer a statistically valid random sample, but the methodology for calculating it was correct. And if we had used those cases, that sample in that extrapolation, we would have arrived at a faulty extrapolation. So in that case, it worked. It did exactly what it was supposed to do. In answer to your other question Mr. Chairman, this is money that, through investigation, the State has established never should have gone to the provider in the first place. Before we even get to the SOAH hearing, there's an opportunity to explore areas where we can agree and areas where we don't agree. The provider has as many opportunities to supplement the data that they give us or extrapolate or explain or do anything they want, before it gets to a SOAH hearing. But the process established in State law for recovering the overpayment that belongs to the State in the first place, it is not, and I think this is important to note, it is not the providers' property, it is the State's property. The process for getting that money back rests

**Rep. Raymond:** If you're right, but if you're wrong, it isn't.

**Stick:** And if we're wrong, Mr. Chairman, then the Appeals Court or the SOAH judge makes that determination.

**Rep. Raymond:** Let me ask you something, let me ask you something. Just, let's say we pass the Bill that says, you know, any claim that's over half a million dollars, you gotta go to court, if the person wants to go to court. Would you feel comfortable with that?

**Stick:** I don't have an opinion about that, Mr. Chairman, I mean that's the legislative

**Rep. Raymond:** You can have an opinion if you're comfortable with that.

**Stick:** I'm sorry?

**Rep. Raymond:** You can have an opinion if you're comfortable with that. Whether your office could handle that, or the State of Texas could handle that just fine.

**Stick:** Mr. Chairman ...

**Rep. Raymond:** Are you comfortable that the State could handle that just fine?

**Stick:** I'm comfortable executing any law that the State of Texas

**Rep. Raymond:** Right.

**Stick:** deems as appropriate.

**Rep. Raymond:** But you're working on these cases, Jack. And you've worked for the State as a prosecutor and you're working in this position now. What I'm asking you is, are you confident in your cases that if, you know, if you're charging somebody and we pass a law that says if they want to go to court to try the case, and show their side of it, are you comfortable in that scenario that you guys are going to do fine, the State will do fine?

**Stick:** The burden of proof would be no different in SOAH than it is in district court.

**Rep. Raymond:** So you, so again, you'd be fine with it.

**Stick:** Mr. Chairman, I think the answer is, if we're going to win at an administrative hearing, I believe that we would win in district court.

**Rep. Raymond:** Then you, then you shouldn't have any problems.

**Stick:** I don't,

**Rep. Raymond:** OKAY

**Stick:** Mr. Chairman, I neither have a problem, I don't support or oppose the Bill. I'm just here to

**Rep. Raymond:** OH no, no, no

**Stick:** tell you what the effects would be.

**Rep. Raymond:** Well, look man, I know that technically people don't, with agencies, don't support or oppose. However, it, you know, you give us opinions, we asked for your opinions on how this, you know, if a Bill that's being considered, is passed, how it would affect your work or the agency. I hear you saying, and I don't want to misquote you here or mischaracterize, but I hear you saying, if this Bill is passed, and we as a Legislature feel like we're giving people, folks in the private sector, who are being accused of something by a governmental entity in a very significant way, we're giving that person in the private sector the opportunity and the right to the due process of going to trial and defending their case. And I hear you saying that you guys would handle that just fine, because if you're putting forth a case, you don't care who's in front of you, you feel comfortable and confident that you're going to do fine.

**Stick:** Mr. Chairman, the Attorney General's Office would represent the State in a district court so

**Rep. Raymond:** But you'd work with him.

**Stick:** Of course we would.

**Rep. Raymond:** Yeah. So, you know, you'd still be involved in it.

**Stick:** My, I guess Mr. Chairman, in direct response to your question, my opinion on this is, is that the cases that we advance are all cases where we have established, by a sufficient level of proof to meet the burden of proof, that there has been an overpayment. Whether that payment was inadvertent on the part of the provider or intentional on the part of the provider, I'm not passing judgement at this point, but I think we would be able to establish an overpayment.

**Rep. Raymond:** Let me ask you a small question and I'll let you go, I don't know if other members have questions. But, so when you're looking through these files and you find one that, where somebody received a treatment on February the 24<sup>th</sup> but the files says February 22<sup>nd</sup>, is that noted? Is that a violation?

**Stick:** There are 2 types, 3 types really,

**Rep. Raymond:** Just answer on that one if you don't mind and then you can

**Stick:** I've got to answer it this way Mr. Chairman. I understand what you're asking, I'm going to give you the answer. There are 3 types of violations: one is a violation that would result in a 100 percent recoupment; one is a violation that would result in a delta recoupment, the difference between what was billed and, or what was paid or what should have been paid; and then what we would call a Z-code violation, it's a violation but we don't recoup, that would be a z-code violation.

**Rep. Raymond:** So it's a violation?

**Stick:** It's a violation that would not result in either a penalty of any kind

**Rep. Raymond:** Okay, when you're looking at a file,

**Stick:** Yes

**Rep. Raymond:** And you look at, and at the end of it you find 6 violations in that file.

**Stick:** Right.

**Rep. Raymond:** And one of them was that the person received a treatment on February the 24<sup>th</sup> but the record says February 22<sup>nd</sup>

**Stick:** Right.

**Rep. Raymond:** So it's however you score that.

**Stick:** Right.



**Rep. Raymond:** It's a Z violation, but it's a violation.

**Stick:** It's a zero.

**Rep. Raymond:** Okay.

**Stick:** It's not calculated as part of the extrapolation.

**Rep. Raymond:** It doesn't count, it doesn't matter.

**Stick:** No Sir. We would note it, we would tell them about it, we'd say, watch your record-keeping. But it doesn't result in them losing any money.

**Rep. Raymond:** Okay. Members, any questions? Thank you.

**Stick:** You're welcome.

(Chairman then calls next witness, Dr. Dunn).

**Rep. Raymond:** Mr. Stick, you want to come up and state your name for the record?

**Stick:** Sure. I'm Jack Stick. I work for the Inspector General's office.

**Rep. Raymond:** I know you deal with a lot of stuff so maybe you don't remember this case.

**Stick:** I do. I remember Dr. Dunn very well. Mr. Chairman I want to clarify one of my earlier answers to you, it was on the fiscal note. One of the other reasons, one of the drivers for that fiscal note, is that the Bill as it is written is that it applies to all of OIG and not just Medicaid provider investigations. So there would be a significant increase in the number of cases that we would be litigating at different levels. I just wanted to be clear about that. I do remember Dr. Dunn's case, and Dr. Dunn came to an informal conference with us and explained his process. And I think it's important to note that, I am assuming that based on Dr. Dunn's verbal permission to discuss the case, that the confidentiality that he would normally enjoy is confidentiality that he's waving and that this will substitute for written permission. But Dr. Dunn had a case where we suspected there was some level of fraudulent behavior that had occurred and I don't recall exactly what his overpayment was, but hopefully that information will be here in a moment or two. Dr. Dunn came in with his attorney, Mr. Anderson, and explained to us his practice. And really nothing in what he told us changed my opinion about whether or not fraudulent conduct had occurred. We asked him some specific questions though, and his answers to those questions did change my opinion about whether he had intentionally tried to defraud the government. And I concluded, partially based on his answers, partially based on the physical proof brought to the informal conference, and then partially just based on talking with the man, that whatever had happened was an overpayment but probably wasn't attributable to his intentional or other mental state required for fraud. I did indicate to him that we would look at the financial records as soon as he provided them to us and we would make adjustments. When we review the financial records for a provider, we have an

accountant do the review, and the accountant calculates the amount of cash flow necessary for the company to stay in business. The provider sends us all of the information, all of their expenses, their salaries, everything, and she calculates the amount of money that they need to stay in business. That amount of money apparently, in Dr. Dunn's case, was 49 percent. And so we reduced the payment hold. Now it's important to note two things – one is that Dr. Dunn was represented by an attorney, a very competent attorney who is also a dentist, during that informal. The second thing is we reduced Dr. Dunn's payment hold and I've not heard from anybody up until this very moment that it was an insufficient amount. But as always, Mr. Chairman, OIG works in an area that's sometimes more of an art than a science, and if Dr. Dunn had an issue with the amount of the payment reduction, he's always welcome to petition for an additional reduction. He's always welcome to do that, as is any provider.

**Rep. Raymond:** Okay. Mr. Fallon?

**Rep. Fallon:** Yeah, I'm just trying to, so there was no, in your opinion Sir, there was no, nothing he did that was intentional and yet he said that he was, that he owed a million and a half dollars. So how does that come about?

**Stick:** Representative, for a long time OIG took a long time to process cases, and we let cases go for a long time before we even caught them, so it would be easy in a 4 and a half or 5 year period for anybody with even a reasonable volume of patients, making the same mistake over and over and over again, to rack up a substantial amount of overpayment. That's one of the, one of the things that ties into the question that you asked earlier – if we can reduce the amount of time it takes us to locate the fraud or the overpayment, whether it's intentional or not, we'll reduce the exposure that these providers have.

**Rep. Fallon:** So, in other words, just in layman's perspective, service was supposed to be charged \$1000 was charged \$1200 by accident, repeatedly, and adds up to a big number.

**Stick:** Exactly.

**Rep. Fallon:** Okay. But in your view it wasn't criminal intent, it was just an oversight.

**Stick:** I didn't see, I didn't see anything there that I would have picked up as a prosecutor.

**Rep. Fallon:** In all your time doing this, have you ever seen anybody undercharged repeatedly?

**Stick:** No.

**Rep. Fallon:** Okay. Oh, Mr. Chairman, do you mind while we have the Commissioner up here, do you have any comments

**Rep. Raymond:** Do I mind what now?

**Rep. Fallon:** Pardon?

**Rep. Raymond:** Do I mind what?

**Rep. Fallon:** Hi, how are ya? [laughing] I just want to ask another question while we have Mr. Stick up here.

**Rep. Raymond:** Yes, one more.

**Rep. Fallon:** Do you have any comments on misusing testimony?

**Stick:** I do, and I appreciate the opportunity to clarify a couple of things. Mr. Houston was the Director of the Sanctions Division for a period of time, from the time I began working as the Deputy Inspector General, he made a number of statements that I think need clarification. The first one was that there was no vetting process in the type of experts that OIG employed. Mr. Houston wasn't involved in that process at all and so I don't know that he would have any experience in that area or any foundational knowledge to venture an opinion to this Committee. He indicated that the agency had retroactively applied a definition of ectopic eruption in order to place a 100 percent hold on providers. The agency had not developed a definition of ectopic eruption because we hadn't looked at orthodontic providers, and so it just wasn't possible for us to do that retroactively.

In terms of retroactive application of anything, OIG's business by definition is retroactive. We are authorized to go back up to 5 years to review medical records. It's not possible for us to look prospectively at somebody's billings, so it's all a retroactive application for that provider on those bills that the provider submitted. He indicated that good cause was no longer sent to an accountant and that a decision about whether to reduce the payment hold is a decision resting with the deputies. As you can see from Dr. Dunn's case, that's not the case we do send financial good cause to an accountant.

Other types of good cause, access to care for example, would rest with the deputies and the Inspector General. A couple of other points. He indicated that a case could take years and a payment hold investigation could take 8 months. One of the things is, or one of the points that Mr. Houston makes is, is that the length of time a case takes adversely affects the provider. And I do think that that is true to a certain degree.

The distinction that I would draw however is that a payment hold is completed, the payment hold investigation is completed by the time the provider comes in for an informal conference. So there wouldn't be a delay, somebody wouldn't be sitting on payment hold for 8 months waiting for us to complete an investigation. In point of fact, if we weren't ready at the informal, they would know that and be able to set a case for a hearing at SOAH immediately, and we would essentially be caught without any evidence, so we don't approach it that way. He finally indicated that he had some concern about OIG adequately preparing cases, and, you know, to my knowledge Mr. Houston litigated two cases at SOAH prior to coming to OIG. He litigated no cases at OIG in the entire time he was there.

One of the frustrations that I experienced as the Deputy Inspector General in charge of these cases at the investigative stage, was finding somebody over in Mr. Houston's position who would

actually advance the case. Mr. Houston would take months and months and months to refer cases back for additional investigation, which would in fact create the exact situation that he complained of here.

So by avoiding, by avoiding that, by pushing cases through more quickly, we effectively afforded providers the opportunity to meet with us sooner and to litigate their cases sooner if they want to. Again, I want to reiterate one significant fact which is, that out of 110 providers on payment hold right now, only 1 has availed itself to the right of a hearing.

And one of the things that I look at as an investigator and as an attorney is, if you are holding \$7 million dollars of my money, if you're telling me that I can't have that money while you're doing the investigation. But I've got an out, I've got any out. I can go to you and talk to you. I can go to SOAH and try to get my money, and even if I lose in SOAH, go to a district court for substantial evidence review. If I know that I'm right, I'm going to get that hearing right away. And so far we've just not seen that happening. Mr. Chairman, Dr. Dunn had \$2.3 million in identified potential overpayments with an 86 percent error rate, I just wanted you to have that information.

**Rep. Raymond:** So that's 86 percent error rates on the 70 files that you found, that you took from his office which you said 3 of them – I mean, he's still back there, I'll call him back up.

**Stick:** Right. I'm not sure what Dr. Dunn was talking about when he was talking about 3 cases. As I recall, he brought 3 cases with him and we discussed 3 cases, which convinced me that there was more going on here favorable to Dr. Dunn. It doesn't really change whether or not there is an overpayment. It could potentially change that. But it certainly changes the mental state required to make me comfortable with a 100 percent payment hold.

Now I will tell you, Mr. Chairman, if Dr. Dunn comes in for an informal conference on the underlying overpayment, and he brings in case files and he says, 'Look, you said that I didn't see the patient on this day. But I had a glitch in my system and I made the notes in handwriting over here, you know, I would say that a tie goes to the provider, but it's not even a tie. I mean, if it's even within reason, we give it to the provider. And we direct all of our expert witnesses to do the same thing. So by the time we arrive at the error rate of 86 percent, it's because the expert witness reviewing the record has given every benefit of every potential doubt to the provider. And then when the provider comes to talk to us and presents additional evidence, we again give every potential benefit of every doubt to that provider. Again, so that error rate for Dr. Dunn may be reduced further.

**Rep. Raymond:** So, just so I'll be clear in my own mind – they just handed you a piece of paper – 86 percent, say that again?

**Stick:** Of the files that we reviewed, 86 percent

**Rep. Raymond:** Of the files that you reviewed, hold on, that you said were 70 files – seven zero – so we'll call him back up, but of those 70 you're saying 86 percent of them

**Stick:** Had recoupable errors. And those recoupable errors, when extrapolated to the total universe of the codes that we selected, amounted to \$2.3 million dollars.

**Rep. Raymond:** We'd be glad to call you back up doctor. Okay. Mr. Fallon?

**Rep. Fallon:** So if you did indeed review 70 cases as he indicated, that means that 60 of them had errors? That's roughly 86 percent?

**Stick:** Yes.

**Rep. Fallon:** Okay. That makes it, and so it's not 1.5? Does he, is the State looking actually to recoup \$2.3 million?

**Stick:** The State would seek to recoup \$2.3 million, that's where it is right now. Let me clarify one thing. We may not find 60 files with errors, because there are different levels of review. We could review based on patients. We could review based on claims. So your doctor submits a claim for the visit, you had 8 things done, there is a claim but it has 8 details in it. So we can review at the patient level, at the claim level, at the detail level, or at the dollar level. And we have found that the most accurate method of calculating overpayment, is either the detail level or the dollar level because that focuses in. For example, if I found there was an error in Chairman Raymond's claim, and I used him, I'm sorry I, as a patient, I was looking at the patient level, then all of the dollars associated with the Chairman would be in error. And we know that's not the case right. So you could statistically say that he had, that's part, that's a way to collect or to calculate an overpayment, but it's not an accurate and fair way. The closer you get to exactly what you're looking for, the more accurate it's going to be. So in this case, it might have been the case that 60 files had errors or it could be that 50 files had errors, but at the detail or dollar level it amounted to the 86 percent.

**Rep. Fallon:** So we have 60 files we're looking at. In each file, somewhere there would be an error, up to 86 percent of those files would have errors somewhere, is that ...?

**Stick:** Yeah, I think it's most likely to say that of those 70 files, somewhere in the neighborhood of 60 had errors. Theoretically, more can have errors but they would be those z-code errors we don't recoup on. It's also possible that fewer would have errors, fewer files would have errors, but the files that did have errors, would have more errors. So for example, if we knew that he was making an error, a 100 percent recoupable error, every time he put a widget in, and that in your case he put 10 widgets in your mouth, but every other case he put in either no widgets or 1 widget, you would have a higher error rate in your one case that would be calculated as part of your 86. So we look at the thing that he did and the dollar value thing that he did, in calculating the error rate. It's the fairest way of arriving at an accurate overpayment rate.

**Rep. Fallon:** Okay, thank you.

**Rep. Raymond:** Again, the way I basically understand it, following Representative Fallon's line of questioning, is that the totality of the work that he did, the claim that he submitted, he could have, one patient may have had one thing done to them but patient number two may have had 10 things

done to them. So sort of the totality of the work, that 86 percent of it, was bad. Shouldn't have been charged to us. Right?

**Stick:** Correct, or there was some recoupment. See

**Rep. Raymond:** Why don't we call him back up? 'cause man, somebody's not telling the truth or somebody is just – something's wrong here. So if you don't mind, doctor state your name for the record one more time.

(continues with Dr. Dunn's testimony and carries on with other witnesses for the rest of the day.)