ATTORNEY GENERAL OF TEXAS
GREG ABBOTT

November 22, 2013

VIA Email carole.hurley@hhsc.state.tx.us

Honorable Carole Hurley
Chief Administrative Law Judge
Director, Appeals Division
Texas Health & Human Services Commission
PO Box 149030-MC W-613
Austin, Texas 78711-3025

RE: **SOAH DOCKET NO. 529-13-0997; *Antoine Dental Center v. HHSC, Office of Inspector General***

Dear Judge Hurley,

Enclosed for the Executive Commissioner's consideration in the above-referenced matter, please find the *Inspector General's Exceptions to the Proposal for Decision.* Also attached is a proposed order for the Executive Commissioner's consideration. The Inspector General respectfully requests the opportunity to present oral argument in support of these *Exceptions.*

If you have any questions, feel free to contact me at the number below.

Respectfully submitted,

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Enclosures

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Hon. Howard S. Seitzman, SOAH (*via Hand-delivery*)
Hon. Catherine C. Egan, SOAH (*via Hand-delivery*)

SOAH DOCKET NO. 529-13-0997
HHSC-OIG CASE NO.: P2011131652384891

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

INSPECTOR GENERAL'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

TO THE HONORABLE EXECUTIVE COMMISSIONER:

NOW COMES the Inspector General of the Texas Health and Human Services Commission ("Inspector General"), in the above-entitled and numbered cause, by and through his counsel of record, and files these, his Exceptions to the Administrative Law Judges' (ALJs) Proposal for Decision, pursuant to the Administrative Procedure Act, Tex. Gov't Code §§ 2001.001 *et. seq.,* and 1 Tex. Admin. Code §§ 155.507(c)(1), 357.497.

In support of these Exceptions, the Inspector General will show: HHSC Medicaid policy provides a limited orthodontia benefit; Antoine Dental Center (ADC) submitted fraudulent or willfully misrepresented prior authorization requests and claims for reimbursement; ADC submitted claims for services not reimbursable; and ADC failed to maintain or provide records as required by law. Under applicable law and considering the

prima facie evidence of record, the Inspector General has met his burden, and the Executive Commissioner should maintain the 100% payment hold against ADC.

I. INTRODUCTION AND BACKGROUND

Pursuant to Tex. Gov't Code §§ 2001.058(e), and 2001.062(a)(2); and 1 Tex. Admin. Code §§ 155.507(c), and 357.497, the Inspector General respectfully excepts to the ALJ's Seitzman's and Egan's Proposal for Decision ("PFD"), dated Nov. 4, 2013.[1] Specifically, the Inspector General excepts to proposed findings of fact (FoF) numbers 10, 21, 26, 29, 39, 40, 41, 42, 45, 46, 47, 48, 49, 50, 54, 55, and 57; to proposed conclusions of law (CoL) numbers 4, 10, 13, 14 and 16; and to the ALJs' ultimate recommendation in this case.

The ALJs' findings and conclusions violate three principles fundamental to Medicaid integrity: (1) Medicaid policy is defined solely by HHSC (not by providers); (2) Medicaid providers, by voluntarily enrolling in Medicaid, assume a duty to know and understand Medicaid law, rules, and regulations; and (3) Medicaid patients are treated to the same standard of care as the general population.

Because the ALJs' proposed findings, conclusions, and analyses are erroneous and illogical, based on misapplications or misinterpretations of applicable law (including the rules of evidence) and administrative rules, and are inconsistent with Texas Medicaid policy, and because there is sufficient evidence to justify a payment hold, the Executive

[1] These exceptions are filed within 15 days of service of the PFD, as required by 1 Tex. Admin. Code §§ 155.507(c)(1) and (2); 357.497.

Commissioner should reject or modify their recommendation and maintain the payment hold until the conclusion of the overpayment hearing.

A. Summary of the Argument

The Inspector General will show that the ALJs failed to properly interpret and apply applicable State law, HHSC rules, and Texas Medicaid policy. *See* Tex. Gov't Code § 2001.058(e)(1). The ALJs failed to properly interpret the Medicaid benefit for orthodontic treatment, drastically expanding the benefit beyond the policy defined by HHSC, and beyond the clear limitations prescribed in Texas law. The ALJs also failed to enforce the duty of providers to know, understand and comply with Medicaid requirements. The ALJs then applied their errors of law and policy to the facts in the record and wrongly concluded that the Inspector General did not meet his evidentiary burden to maintain a payment hold based on credible allegations of fraud. As a result of their misapplication of law and policy, the ALJs ignored *prima facie* evidence that 61 of the 63 HLD scores in the ADC sample had reliable indicia of fraud.

Further, although the ALJs found that the Inspector General presented *prima facie* evidence of record keeping violations, they failed to appreciate how critical HHSC's record-keeping requirements are to the effort to protect Medicaid from waste, fraud and abuse. Mistakenly, the ALJs determined that these violations did not rise to a substantive level of concern.

The ALJs' findings, conclusions, and analyses are also erroneous to the extent that they rely on a prior administrative decision that was incorrect and should be changed. *See* Tex. Gov't Code § 2001.058(e)(2).

Based on their misinterpretations of Medicaid policy and misapplications of the law, the ALJs recommend that the Executive Commissioner order the Inspector General to lift the payment hold in its entirety. *Id.* at 42. This ultimate, non-binding recommendation is insufficient to protect the integrity of the Texas Medicaid program. This recommendation also renders the Inspector General's enforcement powers meaningless, by effectively negating the prohibition on providers from committing program violations.

The Executive Commissioner, therefore, should not adopt the ALJs' recommendation and should, instead, order the Inspector General to maintain the payment hold. *Allen-Burch, Inc. d/b/a The Fare v. Tex. Alcoholic Beverage Comm'n*, 104 S.W.3d 345, 349, 352 (Tex. App.–Dallas 2003, no pet.) (if the finder of fact determines that violations of state law have occurred, the referring agency has the ultimate discretion to determine the appropriate sanction).

B. The Inspector General has broad discretionary authority to protect the fiscal integrity of the Medicaid program by imposing payment holds on providers suspected of fraud or noncompliance with Medicaid requirements.

This is an administrative payment hold action initiated by the Inspector General to enforce Texas Medicaid program integrity requirements. The Inspector General is responsible for the investigation of waste, fraud and abuse in the provision of health and human services "and the enforcement of state law relating to the provision of those services." Tex. Gov't Code § 531.102; *see also* 1 Tex. Admin. Code § 371.1 (Purpose

and Scope).[2]

1. The Inspector General must impose a payment hold if he receives a "Credible Allegation of Fraud."

The Inspector General 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."[3] Tex. Gov't Code § 531.102(g)(2) (2011).

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

A credible allegation of fraud "may be an allegation, which has been verified by the State, from any source, including but not limited to the following: . . . claims data mining[,] . . . patterns identified through provider audits [or] law enforcement

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[2] Chapter 32 of the Human Resources Code provides for the imposition of damages and penalties against a person who presents or causes to be presented to the department a claim that "contains a statement or representation the person knows or should know to be false." Tex. Hum. Res. Code § 32.032(b)(1). The statutory authority for the rules governing the Inspector General includes both chapters 32 and 36 of the Human Resources Code. *See* Tex. Gov't Code § 531.001 *et seq.*; and 1 Tex. Admin. Code § 371.1605 (2005). Specifically, the Inspector General may take administrative enforcement measures against a person based upon a violation of chapter 32 or chapter 36 of the Human Resources Code. 1 Tex. Admin. Code § 371.1617(5)(B) (2005).

[3] The mandatory payment-hold statutory framework was introduced through provisions of the Affordable Care Act, which amended the Social Security Act at sections 1862(o) and 1903(i)(2)(c). Section 1862(o) broadly requires suspension of payments pending an investigation of credible allegations of fraud. 42 U.S.C. § 1396b(i)(2)(c). Section 1903(2)(c) provides for withholding of federal funds where the State fails to implement section 1862(o). 42 U.S.C. § 1395y(o).

investigations." 42 C.F.R. § 455.2. 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." *Id.*

Evidence is presumed to have indicia of reliability and may be adopted by a court "without further inquiry if the defendant fails to demonstrate by competent rebuttal evidence that the information is materially untrue, inaccurate or unreliable." *United States v. Floyd*, 343 F.3d 363, 372-73 (3d Cir. 2003) (citing *United States v. Carbajal*, 290 F.3d 277, 287 (5th Cir. 2002)); *see also California v. Maki*, 704 P.2d 743, 750 (Cal. 1985) (a document will be considered to have a reasonable indicia of reliability where it has the party's signature on its face and it is "the type relied upon by parties . . .").

Although the federal requirement that the Inspector General impose a payment hold upon identifying a credible allegation of fraud is mandatory, *whether* such evidence exists is a discretionary determination resting with the Inspector General. No law or regulation exists identifying specific fact situations which constitute a credible allegation of fraud. Rather, that decision lies entirely within the judgment of the Inspector General.

The Inspector General also has authority to impose a discretionary payment hold if he has "reliable evidence" a provider "committed fraud or willful misrepresentation regarding a claim for reimbursement." Tex. Hum. Res. Code § 32.0291(b) (2003).[4] The discretionary authority in chapter 32 of the Human Resources Code is duplicative of the

[4] Effective September 1, 2013 section 32.0291(b) of the Human Resources Code was amended. A new subsection (c) was added to the statute. The changes are prospective and do not apply to this case, which was heard in May, 2013.

mandatory authority in Government Code chapter 531. Importantly, however section 32.0291(c) includes the standard for maintaining the payment hold: "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) (emphasis added).

2. If the Inspector General presents *prima facie* evidence of fraud, the payment hold must be maintained.

The Inspector General's burden to maintain the payment hold under section 531.102(g)(2) of the Government Code and section 32.0291(c) of the Human Resources Code, is to show by *prima facie* evidence that he has received reliable or credible evidence that ADC has committed fraud or made willful misrepresentations. This means that the Inspector General must present *prima facie* evidence that is relevant, credible and material, that ADC acted: (1) with knowledge of the truth or falsity of its representations to Medicaid; (2) with conscious indifference to the truth or falsity of its representations to Medicaid; or (3) with reckless disregard of the truth or falsity of its representations to Medicaid. Tex. Hum. Res. Code §§ 32.0291(c) (describing standard for maintaining payment hold), and 36.011 (defining culpable mental state for violations of the TMFPA).

3. The Inspector General also has the authority to impose a payment hold for "program violations."

The Inspector General also has additional regulatory authority to impose a payment hold for program violations. *See* 1 Tex. Admin. Code § 371.1703(b). Program violations include, among other things:

- 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. 1 Tex. Admin. Code § 371.1617(1)(A)-(C), (I);
- Submitting claims that are not reimbursable by Medicaid. *Id.* at (1)(K);
- 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. *Id.* at (2)(A);
- Failing to comply with the terms of Medicaid provider agreement, provider policy, or procedure manuals. *Id.* at (5)(A), (5)(G).[5]

For a payment hold based on non-fraud program violations, the Inspector General has no burden to show ADC's mental state. Rather, the Inspector General merely must present *prima facie* evidence showing the violation occurred. However, if the Inspector General presents *prima facie* evidence that ADC's violations are the result of fraud or willful misrepresentation, then the Executive Commissioner *is required by law* to maintain the payment hold. Tex. Gov't Code § 531.102(g)(2); 42 C.F.R. § 455.23(a)(1).

C. The facts presented by the Inspector General meet the threshold to maintain the payment hold.

Petitioner, ADC is a Texas Medicaid orthodontic provider. Between November 1, 2008 and August 1, 2011, ADC was paid over $8,104,875.00 by Texas Medicaid. PFD FoF No. 3. Dr. Behzad Nazari, ADC's owner is a general dentist, not an orthodontist. He does not have any specialized training in orthodontia. R.R.,Vol. 4 at 57-58, 69. Dr. Nazari estimated 60 to 70 percent of ADC's patients in 2010 were Medicaid patients.

[5] Program violations are also listed in the Texas Medicaid Provider Procedures Manual. *See, e.g.*, Ex. R-15 at § 1.4.3 (Retention of Records and Access to Records and Premises, citing to 1 Tex. Admin. Code § 371.1617); *Id.* at § 1.5 (setting out Medicare/Medicaid Waste. Abuse and Fraud Policy, describing potential sanctions, and listing each program violation contained at section 371.1617).

R.R.,Vol 4. at 33-34. ADC's two Houston clinics saw 2,000 to 2,500 new Medicaid patients for orthodontic evaluations per year during 2008 to 2011. *Id.*

On April 4, 2012, the Inspector General instituted a 100% payment hold on claims for reimbursement by ADC because the Inspector General determined that credible allegations exist that ADC has engaged in fraud and willful misrepresentation of information submitted to Medicaid in support of ADC's request for prior approval (PA) of orthodontic services for Medicaid recipients. In addition, the Inspector General determined that ADC committed non-fraudulent violations of Medicaid requirements, which also justified imposition of a payment hold. Ex. P-82a.

Specifically, based on expert review of ADC patient records by orthodontic experts retained by the State and an OIG field investigation, the Inspector General imposed a payment hold based on *prima facie* evidence that: (1) ADC 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). Ex. P-82a. 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). Ex. P-82a.

ADC requested an administrative hearing to appeal the payment hold. After notice, ALJs Seitzman and Egan with the State Office of Administrative Hearings ("SOAH") conducted the hearing in Austin, Texas, on May 28-31, 2013.

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* evidence [6] that is relevant, credible and material, that ADC committed fraud or willful misrepresentation in connection with its orthodontia PA requests and claims. Tex. Hum. Res. Code § 32.0291(c) (2003).

The evidence established that the Inspector General initiated this investigation of ADC in 2011. R.R., Vol. 3, 195:1. During the time period of the investigation, ADC treated approximately 6,550 Medicaid patients. RR, Vol. 3 at 200:12. 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). R.R.,Vol. 3 at 200:20-208:7.[7] The Inspector General pulled a statistically valid random sample of patient files. The 63 files were reviewed by two OIG experts: Dr. Charles Evans and Dr. Larry Tadlock.

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[6] "Prima facie" evidence, is evidence that, until its effect is overcome by other 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 writ)).

[7] On page 9 of the PFD the ALJs note in passing that the Inspector General did not present expert testimony regarding the statistical validity of his sampling and extrapolation procedure. However, the Inspector General bears no burden in this proceeding of establishing such validity. The burden on the Inspector General in this payment hold hearing is very low: to show by prima facie evidence that he has received an allegation of violations that is credible or reliable. Tex. Hum. Res. Code § 32.0291(c). In any event, the only evidence in the record regarding the validity of the Inspector General's sampling and extrapolation procedure is uncontroverted. *See* testimony of Deputy Inspector General for Enforcement Jack Stick, at RR, Vol 3, at 201-209.

Both State experts, using the Manuals for the corresponding years of service (2008-2011) concluded ADC inflated HLD scores submitted to Medicaid. R.R., Vol. 3 at 289:23-290:3, 295:22-296:2.

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. *See* summary attached to Inspector General's Closing Argument, Attachment 6, Ex. R49.
- ADC certified that every single one of these 61 patients had six or more ectopically-erupted teeth. Ex. P-64.01 through P-64.63.
- ADC scored 50% or more of the allowable teeth as ectopic on each and every sample HLD scoresheet ADC submitted for comprehensive orthodontics authorization. *See* summary attached to Inspector General's Closing Argument, Attachment 6, Ex. R49.
- Not a single patient in the sample was eligible for Medicaid-covered comprehensive orthodontics without ADC's scoring for ectopic eruption; alternatively, ADC did not submit any narratives for any of the 61 patients, even if services could be justified on other bases. Ex. P-64.01 through P-64.63; R.R.,Vol. 4 at 70:13-19.
- Dr. Kanaan scored 27 patients of the 63 patient sample. Of the 27 patients he scored, he found that 23 (85%) had the same eight teeth ectopic. R-83; R.R.,Vol. 3 at 43-70.
- ADC submitted prior authorization requests for comprehensive orthodontics under the code D8080 for 61 of the 63 patients. Ex. P-64.01 through P-64.63; RR, Vol. 1, 176:14-20, 177:1-16.
- Dr. Kanaan testified that he understood how ectopic eruption is understood in the general practice of dentistry. RR, Vol. 3, 13:15-14:15; 104-105; 112:2-8.
- Dr. Kanaan testified that he does not diagnose his private pay patients differently than his Medicaid patients. RR, Vol. 3, 17:22-25. However, he also testified that he does not evaluate private pay patients for ectopic eruption. RR, Vol. 3, 96:6-9.
- ADC is the subject of at least three investigations by the Inspector General for violations of Texas Medicaid regulations. RR, Vol. 3, 194:7-195:6.

Dr. Larry Tadlock, D.D.S.,[8] the Inspector General's testifying expert orthodontist testified as follows:

- ADC submitted HLD scoresheets that were false and misrepresented the condition of the patient's teeth. R.R.,Vol. 1 at 176:14-20, 177:1-16.
- 61 of the 63 HDL scoresheets were incomprehensible because ectopic eruption is an extremely rare condition. Only between 1.5 and 9% of the population have even one ectopic tooth. R.R.,Vol. 1 at 173:3-6; *see also* R-51 at 8 (Thilander article describing ectopic eruption as an "anomaly" that occurred in only 1.5-1.6% of a sample population of 4724 patients).
- For ectopic eruption to occur more than once in the same patient is "infinitesimally smaller." R.R.,Vol. 1 at 174:16-18.
- Because ectopic eruption is exceedingly rare, occurring in between 1.5 - 9% of the population, the chances of every patient in the sample having 6 or more ectopic teeth in the front of their mouths "not possible." R.R.,Vol. 1 at 173:3-6, 175:1.
- The chance of 100% of full-banding patients in a sample having not only one instance of an exceedingly rare condition, but always at least six instances, and always two or more bilateral instances, is "zero. It's not possible." R.R.,Vol. 1 at 175:1, 176:23; R-49.

The Inspector General thus presented *prima facie* evidence that ADC committed fraud or willful misrepresentation in connection with its orthodontia PA requests and claims. Tex. Hum. Res. Code § 32.0291(c). The evidence is relevant, credible, and material. *Id.* It also bears "indicia of reliability" because it is based in large part on ADC's own PA requests and claims records, as well as on competent expert testimony.

[8] Dr. Tadlock has been an orthodontist since 1988 and is a board-certified orthodontist. He is also an Assistant Clinical Professor of Orthodontics at Baylor College of Dentistry, responsible for supervising patient care, teaching orthodontic residents, and performing research on orthodontics. Furthermore, he is one of only eight Directors of the American Board of Orthodontics in the United States. As an ABO Director, Dr. Tadlock is responsible for creating, writing, and administering board certification exam for orthodontists. Specific to his experience with Medicaid, Dr. Tadlock has treated Medicaid patients who were accepted and treated at Baylor. He estimates he has assessed "several hundred" HLD score sheets for potential Medicaid patients while at Baylor. RR, Vol 1 at 146-48.

Floyd, 343 F.3d at 372-73. At a bare minimum, the evidence shows ADC acted with conscious indifference or reckless disregard when submitting PA requests to Texas Medicaid. Tex. Hum. Res. Code § 36.011 (defining culpable mental state for committing unlawful acts under the TMFPA).

2. The Inspector General presented *prima facie* evidence that ADC billed Medicaid for services that are not reimbursable.

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 dentition." Ex. R-15 at § 19.19.1 (2009). 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[9]. Exs. P-15 at P15-0019, P-56 at P56-0015, P-60 at P60-0004 (ADC Prior Authorization Request Forms for underage Patients 15, 56, and 60, respectively, requesting "D8080"). R.R. Vol. 4 at 54:8-14. Therefore, ADC violated 1 Tex. Admin. Code § 371.1617(1)(K) and (5)(G).

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[9] 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 TMPPM "Full banding is allowed on permanent dentition only, and treatment should be accomplished in one stage and is allowed once per lifetime. ***Exception: Cases of mixed dentition when the treatment plan includes extractions of remaining primary teeth or cleft palate."'*** Further, as 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. PFD at 34. 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. Ex. P10-0005, and P10-0006 (patients submitted for interceptive treatment under code D8060).

3. The ALJs correctly found that the Inspector General presented prima facie evidence that ADC failed to maintain and provide or provide records as required by law.

Providers voluntary agree "to maintain records and to provide access to and copies of such records." R-01, at 0024. Failure to maintain or provide records is a program violation. 1 Tex. Admin. Code § 371.1617(2)(A). The Inspector General presented evidence, *and, indeed, the ALJs found*, ADC failed to keep necessary records for the required five-year period. 22 Tex. Admin. Code § 108.8(b).[10] ADC failed to maintain and/or provide investigators with the following records for patients in the 63-patient sample:

- HLD forms (five patients, or 7.9% of the sample);
- pre-treatment x-rays (two patients, or 3.2% of the sample);
- extraction requests (six patients, or 9.52% of the sample);
- treatment cards (six patients, or 9.52% of the sample); and
- models (four patients, or 6.3% of the sample).

The record reflects, then, by *prima facie* evidence that 61 of the 63 PA requests submitted by ADC in the sample include false statements or material misrepresentations; that ADC made claims for comprehensive orthodontia (full banding) for three patients in the sample who were not eligible; and that ADC failed to maintain proper records in 23 instances in the sample.

[10] A provider is required to submit an orthodontic treatment plan; cephalometric radiograph with tracing models; completed and scored HLD score sheet with diagnosis of Angle class (26 points required for approval of non-cleft palate cases.); facial photographs; full series of radiographs or a panoramic radiograph (diagnostic quality films are required). Ex. R-15 at § 19.19.2 (2009).

II. WHEN ALJs MISAPPLY OR MISINTERPRET LAW, EXECUTIVE COMMISSIONER HAS AUTHORITY TO MODIFY THEIR PROPOSAL

The Administrative Procedure Act (APA), chapter 2001, Government Code, governs contested proceedings before HHSC. The APA expressly defines the Executive Commissioner's discretion to change proposed findings of fact and conclusions of law prepared by ALJs after contested case hearings. The APA provides, in pertinent part, as follows:

> (e) A state agency may change a finding of fact or conclusion of law made by the administrative law judge, or may *vacate* or *modify* an order issued by the administrative law judge, only if the agency determines:
>
> (1) *that the administrative law judge did not properly apply or interpret applicable law, agency rules, written policies provided under Subsection (c), or prior administrative decisions;*
>
> (2) *that a prior administrative decision on which the administrative law judge relied is incorrect or should be changed*; or
>
> (3) that a technical error in a finding of fact should be changed.

Tex. Gov't Code § 2001.058(e) (emphasis added). Thus, the Executive Commissioner is authorized to change incorrect legal and policy determinations by the ALJs. *See* Tex. Gov't Code § 2001.058(e)(1); *see also Tex. Dep't of Licensing & Regulation v. Thompson*, 03-11-00316-CV, 2013 Tex. App. LEXIS 8832, at *6 (July 18, 2013, pet. filed) ("An agency enjoys ***complete discretion*** in modifying an ALJ's findings and conclusions when those findings and conclusions reflect a lack of understanding or misapplication of the existing laws, rules, or policies.") (quoting *Smith v. Montemayor*, 03-02-00466-CV, 2003 Tex. App. LEXIS 5099 (Tex. App.—Austin June 19, 2003, no

pet.) (emphasis added)). *Montemayor* is directly on point and supports the rejection of the ALJs' recommendation: the Commissioner of Insurance rejected the ALJ's recommendation to grant a license, overturning that recommendation and denying the license. *Montemayor*, 2003 Tex. App. LEXIS 5099, at *16, 26-27; *see also Tex. State Bd. of Pub. Accountancy v. Bass,* 366 S.W.3d 751, 755-56 (Tex. App.—Austin 2012, no pet.)(court affirmed board's rejection of ALJ's conclusion because it misapplied applicable law, rules and policy).

Moreover, an agency has considerable latitude to reject an ALJ's sanction recommendation included in a PFD. Within the bounds of his statutory authority, the Executive Commissioner has broad discretion to change or ignore or overrule the ALJs' recommendation and to determine the appropriate sanction when state law has been violated. Indeed, Texas's jurisprudence is replete with examples of agencies or Commissioners rejecting ALJ sanction recommendations. *See, e.g., Froemming v. Tex. State Bd. of Dental Exam'rs*, 380 S.W.3d 787, 792-93 (Tex. App.—Austin 2012, no pet.) (court affirmed agency's rejection of ALJ's recommendation to suspend instead of revoke license); *Bass*, 366 S.W.3d at 755-56; *Tex. State Bd. of Med. Exam'rs v. Brown*, 281 S.W.3d 692, 700 (Tex. App.—Corpus Christi 2009, pet. denied) ("imposition of additional sanctions was supported and . . . the Board, not the ALJ, determines the penalty"); *see also Fay-Ray Corp. v. Tex. Alcoholic Beverage Comm'n*, 959 S.W.2d 362, 369 (Tex. App.–Austin 1998, no writ) ("an agency has broad discretion in determining which sanction best serves the statutory policies committed to the agency's oversight"); *Firemen's & Policemen's Civil Serv. Comm'n v. Brinkmeyer*, 662 S.W.2d 953, 956 (Tex.

1984) ("The propriety of a particular disciplinary measure . . . is a matter of internal administration with which the courts should not interfere . . ."). [11]

When an agency seeks to change an ALJ's finding of fact, or conclusion of law, it must specifically articulate, in writing, its reasons for each change made. *Thompson,* 2013 WL 3791486, at *4; *Flores v. Emps. Ret. Sys. of Tex.*, 74 S.W.3d 532, 540 (Tex. App.—Austin 2002, pet. denied) (APA requires "a reasoned explanation for each change"); *Pierce v. Tex. Racing Comm'n,* 212 S.W.3d 745, 755 (Tex. App.—Austin 2006, pet. denied) (an agency must state in writing "the specific reason and legal basis for" each change of the ALJ's order, findings of fact, or conclusions of law). *See also Tex. State Bd. of Med. Exam'rs v. Dunn*, 03-03-00180-CV, 2003 Tex. App. LEXIS 9833, at *1 (Tex. App.—Austin Nov. 20, 2003, no pet.) (Board must "establish a reasonable evidentiary basis for rejecting the ALJ's findings and conclusions"). And, there must be a rational connection between an underlying agency policy and the altered finding of fact or conclusion of law. *See, e.g., Heritage on the San Gabriel Homeowners Assoc. v. TCEQ*, 393 S.W.3d 417, 440-41 (Tex. App.—Austin 2012, pet denied); *State v. Mid-South Pavers, Inc.,* 246 S.W.3d 711, 728 (Tex. App.–Austin 2007, pet. denied); *Levy v. Tex. State Bd. of Medical Exam'rs*, 966 S.W.2d 813, 816 (Tex. App.–Austin 1998, no pet.).

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[11] If appealed to district or an appellate court, "an agency's decision in determining an appropriate penalty will not be reversed unless an abuse of discretion is shown." *Allen-Burch,* 104 S.W.3d at 352. Indeed, "the burden is a heavy one" and a reviewing court will not overturn an agency's decision "if there is some reasonable basis in the record for the action taken by the agency." *Dutchmen Mfg., Inc. v. Tex. Dep't of Transp.*, 383 S.W.3d 217, 222 (Tex. App.—Austin 2012, no pet.) (citing *Tex. Health Facilities Comm'n v. Charter Med.-Dallas, Inc.*, 665 S.W.2d 446, 453 (Tex. 1984)).

III. THE ALJs ERRED IN APPLYING TEXAS LAW, HHSC RULES, AND MEDICAID POLICY TO THE FACTS OF THIS CASE

The PFD turns largely on the ALJs' finding that the Inspector General failed to present *prima facie* evidence that is "credible, reliable, or verifiable, or that has indicia of reliability" that ADC has engaged in fraud or willful misrepresentation in filing its requests for prior approval (PA) with Texas Medicaid. PFD at 40-41, proposed FoF Nos. 48-50. The ALJs' erroneous findings rest on the ALJs' incorrect interpretation of Texas Medicaid policy with respect to the scope of the orthodontic benefit allowed by Medicaid policy and the ALJs misapplication of law to fact. The ALJs' analysis reflects a fundamental misapprehension of Texas Medicaid policy and a complete misapplication of law, resulting in flawed findings of fact and erroneous conclusions of law; therefore the Executive Commissioner should modify this PFD and maintain the 100% payment hold against ADC.

Except in rare instances, none of which are present in this case, Medicaid limits its orthodontic benefit to children suffering from a "severe handicapping malocclusion." 25 Tex. Admin. Code § 33.71. Nevertheless, the ALJs found, despite this clear and overriding limitation, that Medicaid policy uses a "definition" of "ectopic eruption" that destroys the limitation. In making this finding, the ALJs ignore both the plain language of the policy and the testimony of the HHSC witnesses – the only witnesses qualified to testify what Texas Medicaid policy means.

A. The ALJs' misinterpretation of "Ectopic Eruption" impermissibly contradicts Medicaid policy and HHSC's intent.

The ALJs erroneously determined Texas Medicaid adopted in the Texas Medicaid Provider Procedure Manual ("TMPPM") a special definition of "ectopic eruption" that was different from, and far more liberal than, the understanding of the term in the general practice of dentistry. PFD at 16-19. This determination is directly contrary to the instructions in the TMPPM to providers to score the HLD conservatively. *See e.g.* Ex. R-15, (2009 TMPPM), at § 19.21 ("Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case.").

This incorrect determination, and the ALJs' faulty companion conclusion - that the so-called definition is subjective - reflects a gross misunderstanding of Texas law and misapplication of Medicaid policy. That gross misunderstanding exists not simply in an academic environment but in a very real financial environment as well. The misunderstanding, if maintained, represents an expenditure of more than a *billion* Title XIX dollars – hardly an expenditure where any reasonable person could expect the State to be vague about whether it intended to authorize that type of Medicaid benefit.

Texas Medicaid requires providers to deliver healthcare services in full compliance "with accepted community standards and with the standards that govern occupations." Ex. R-16, at § 1.6; Ex. R-15, § 19.2. As a result of their erroneous determination regarding ectopic eruption (that there exists a special definition for the Medicaid Program different from any other definition), the ALJs found that none of the HLD score sheets submitted by ADC at issue in this case included false statements or misrepresentations. Consequently, they logically, but erroneously concluded that ADC's conduct was neither fraudulent nor willfully misrepresentative. The key, then, to

correcting the ALJs' findings and conclusions is to reject their faulty construction of Texas Medicaid policy, the orthodontic benefit and specifically, their erroneous interpretation of Medicaid's use of the term "ectopic eruption."

1. Texas Medicaid provides a limited orthodontic benefit.

Medicaid providers, such as ADC, voluntarily apply to enroll in the Texas Medicaid program. Until March 2012, providers such as ADC were reimbursed on a fee-for-service basis. The schedule of fees is published annually in the TMPPM. Texas employs contractors to administer the Medicaid program and process prior approval requests and claims. Texas Medicaid Health Partnership (TMHP) is the prime claims and prior approval contractor for the Texas Medicaid program.[12]

Texas Medicaid provides coverage for services that include dental and, on a very limited basis, orthodontic services to qualifying children. The law severely restricts when Texas Medicaid will pay for orthodontic services:

> Orthodontic services for cosmetic reasons only are not a covered Medicaid service. Orthodontic services must be prior authorized and are limited to treatment of severe handicapping malocclusion and other related conditions as described and measured by the procedures and standard published in the [TMPPM].

[12] TMHP is a coalition of contractors. The prime contractor, ACS Healthcare, has responsibility to process orthodontic PA requests and reimbursement claims. The PFD errs to the extent that the ALJs conflate the PA and claims processing function of TMHP with the Medicaid policy making responsibilities of HHSC.

25 Tex. Admin. Code § 33.71 (Orthodontic Services and Prior Authorization) (emphasis added). Since 2003, the Texas Medicaid program has only reimbursed providers for orthodontic services under three scenarios: (i) for children between the ages of 12 and 20 who have a severe handicapping malocclusion (this age requirement was added in 2008) which is defined by a Handicapping Labio-lingual Deviation ("HLD") score of 26 points or greater; (ii) children up to the age of 20 with cleft palate; or (iii) other medically necessary circumstances such as a head injury involving severe traumatic deviation.[13] The Texas Medicaid program does not pay, indeed never has paid, for cosmetic orthodontics. *See, e.g.*, TMPPM (2011) (Ex. R-17), Vol. 2, § 4.2.24; TMPPM (2010) (Ex. R-16), Vol. 2, § 5.3.24 (same); TMPPM (2009), Vol. 2, § 19.19 (Ex. R-15) (same); TMPPM (2008), Vol. 2 § 19.19 (Ex. R-14). *see also* 25 Tex. Admin. Code § 33.71

[13] The TMPPM states:

> 19.19 Orthodontic Services (THSteps)
>
> - Orthodontic services for cosmetic purposes only are not a benefit of Texas Medicaid. Orthodontic services are limited to the treatment of children who are 12 years of age and older with severe handicapping malocclusion, children who are birth through 20 years of age with cleft palate or other special medically necessary circumstances as outlined in Benefits and Limitations below.
>
> 19.19.1 Benefits and Limitations
>
> Orthodontic services include the following:
>
> - Correction of severe handicapping malocclusion as measured on the Handicapping Labiolingual Deviation (HLD) Index. Refer to page 19-4 for information on how to score the HLD. A minimum score of 26 points is required for full banding approval (only permanent dentition cases are considered).
>
> ***
>
> - Crossbite therapy.
> - Head injury involving severe traumatic deviation.The following limitations apply for orthodontic services:Orthodontic services for cosmetic purposes only are not a benefit of Texas Medicaid or THSteps.

Ex. R-15 at § 19.19.1 (2009).

(same). In all cases, comprehensive orthodontic treatment ("full banding" or "full braces," as opposed to more limited orthodontics), listed as code D8080, is "restricted to clients who are 12 years of age or older or clients who have exfoliated all primary dentition." *See, e.g.,* Ex. R-15 at 19.19.6.

2. Providers must submit prior authorization requests before filing a claim for reimbursement.

Providers must obtain PA before seeking reimbursement from Texas Medicaid for orthodontic services. *See* 25 Tex. Admin. Code § 33.71; *see also* Ex. R-15 at § 19.19.2 ("Prior authorization is required for all THSteps orthodontic services except for procedure code D8660 [this procedure is the initial consultation that pays only $15.00 for reimbursement]). "Prior authorization is a condition for reimbursement; it is not a guarantee of payment." Ex. R-15 at § 19.19.2 (2009). Providers are required to submit truthful and complete information when seeking PA.[14]

The PA application includes the representation by the provider of the treatment necessary to correct a child's severe handicapping malocclusion. To support a finding that a child has a severe handicapping malocclusion, a provider must, *inter alia*, submit a Handicapping Labio-lingual Deviation ("HLD") score sheet with the application for PA.

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[14] Specifically, providers are required to submit:

- An orthodontic treatment plan, which "should incorporate only the minimal number of appliances required to properly treat the case";
- "[c]ephalometric radiograph with tracing models";
- "[c]ompleted and scored HLD score sheet with diagnosis of Angle class (26 points required for approval of non-cleft palate cases.");
- Facial photographs;
- Full series of radiographs or a panoramic radiograph; diagnostic films are required.

Ex. R-15 at § 19.19.2 (2009).

See Ex. R-15 at § 19.19.2 (2009). For the PA request to be approved, the child's condition must rise to the level of a severe handicapping malocclusion, as indicated by a score of 26 or more on the HLD for non-cleft palate cases. *See id.* at § 19.19.2 (2009). Texas Medicaid expects and requires providers such as ADC to complete PA documentation accurately and truthfully to ensure that only those children who qualify receive benefits.

3. Providers must rely on their own medical training in making diagnoses and submitting requests for prior authorization and claims for Medicaid reimbursement.

The HLD index allows providers to score nine conditions in a patient's mouth. The condition most relevant in this case is "ectopic eruption."[15] Contrary to the ALJs' conclusion at page 16 of their PFD, the TMPPM does not define *or redefine* ectopic eruption for the purposes of determining Medicaid eligibility for orthodontic benefits. R.R., Vol. 1 at 103:8-12 (where Dr. Altenhoff testified that the terms in the ectopic eruption instruction are not defined, but are accorded their plain and ordinary meaning in the English language); R.R.,Vol. 3 at 241:5-11 (where Jack Stick, Deputy Inspector General for Enforcement, testified to the same proposition).

As Dr. Altenhoff and Mr. Stick testified, the TMPPM is not a medical text. R.R., Vol. 1 at 111:12-14 (Dr. Altenhoff explaining that providers must understand the manual by virtue of their professional training); R.R.,Vol. 3 at 249:11-250:7 (Mr. Stick explaining that the manual is a billing manual, not an educational document); *see also*

[15] The other eight conditions are cleft palate, severe traumatic deviations, overjet, overbite, mandibular protrusion, open bite, anterior crowding, and labio-lingual spread. *See generally* R.R., Vol. 1, at 63-68.

R.R.,Vol. 2 150:18-22 (ADC's expert, Dr. Orr, explaining the same). The TMPPM does not, and cannot, replace a provider's medical education and training. *Id.* The TMPPM requires, and Texas Medicaid expects, providers to use their medical background, experience, and training to understand any medical terminology referenced in the Manual. The State does not, through the TMPPM or any avenues of communication with providers, instruct providers how to practice dentistry or orthodontics. *Id.* Instead, the TMPPM is, essentially, a billing manual, "not . . . a clinical system in dentistry or medicine." R.R. Vol. 2 at 150:19-21 (testimony of Dr. Orr).

In addition, Texas Medicaid has not created a unique standard of care for Medicaid patients distinct from the standard of care in the dental profession. Indeed, creation of a different set of standards applicable only to Medicaid patients would violate both state and federal law. *See, e.g.,* 1 Tex. Admin. Code § 354.1131(h); *see also* RR., Vol. 3, 250:8-19; Ex. R-14 (2008 TMPPM), § 1.2.5; Ex. R-15 (2009 TMPPM), § 1.4.5 (**Compliance with Federal Legislation. Reminder:** *Each provider must furnish covered Medicaid services in the same manner, to the same extent, and of the same quality as services provided to other patients. Services made available to other patients must be made available to Texas Medicaid clients if the services are benefits of the Texas Medicaid Program.*"). And in fact, all published policy documents promulgated by HHSC require providers to apply the same standards of care to Medicaid patients they apply with the population at large. *See, e.g.*, Ex. R-16, at § 1.6; Ex. R-15, § 19.2.

Therefore, the ALJs' finding that the TMPPM defines ectopic eruption specially and differently than the dental community generally understands it violates state and

federal law and Medicaid policy. Moreover, their conclusion that the so-called Medicaid "definition" is subjective and open to differences in professional opinion is also contrary to Medicaid policy. HHSC, and only HHSC, defines Texas Medicaid policy. The ALJs' findings, if not rejected, would result in an abrogation of HHSC's role in determining public policy and deciding what services are, and are not, reimbursable. By concluding that "ectopic eruption" is, essentially, whatever a dental provider says it is, the ALJs are, in effect, rendering null and inoperative HHSC's determination that the orthodontia benefit is limited to patients exhibiting severe handicapping malocclusion. This finding impermissibly, and absurdly, takes from HHSC officials the policy-making function and turns it over to Medicaid providers, who are obviously incentivized to maximize their reimbursements. The ALJs' analysis allows the fox to guard the hen-house.

4. Providers, by voluntarily enrolling in Medicaid, have a duty to know, understand, and follow Medicaid policy, law, rules, and regulations.

As a voluntary participant in the Medicaid program, ADC was obligated as a matter of law to understand and abide by Texas Medicaid requirements, standards, and procedures. This includes an affirmative obligation on ADC to understand the limitations on Texas Medicaid's orthodontia benefit. *Heckler v. Community Health Servs.*, 467 U.S. 51, 63-65 (1984). *Heckler* is particularly instructive here. The case involved the Government's recovery of payments incorrectly made to a Medicare provider. The provider contended the Government was estopped from recovering because the provider relied on authorization by a fiscal intermediary. *Id.* at 53. The Court rejected the availability of estoppel. "When the Government is unable to enforce the law because the

conduct of its agents has given rise to an estoppel, the interest of the citizenry as a whole in obedience to the rule of law is undermined." *Id.* at 60. The Court found that the provider had lost no legal right because it was never entitled to the money in the first place. *Id.* at 61-62. Moreover, Court found the duty was squarely on the provider to know the provisions under which it received government funds. "As a participant in the Medicare program, respondent had a duty to familiarize itself with the legal requirements for cost reimbursement." *Id.* at 64. The Court noted:

> Justice Holmes wrote: "Men must turn square corners when they deal with the Government" (citing *Rock Island, I& L.R. Co. v. United States*, 254 U.S. 141, 143 (1920)). This observation has its greatest force when a private party seeks to spend the Government's money. Protections of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of law; respondent could expect no less than to be held to the most demanding standards in its quest for public funds. This is consistent with the general rule that those who deal with the Government are expected to know the law and may not rely on the conduct of Government agents contrary to law. *Id.* at 63.

See also, North Memorial Med. Center v. Gomez, 59 F. 3d 735, 739 (8th Cir. 1995) (participants in the Medicaid program have a "duty to familiarize themselves with the legal requirements" of Medicaid procedures). Providers simply may not claim after getting caught in a lie that they interpreted a term in a manner that contradicts Medicaid policy, federal law, and industry-wide understanding of the term.

5. The Executive Commissioner should correct the ALJs' errors of law and misapplications of Medicaid policy.

In construing a statute, a reviewing court's primary objective is to ascertain and give effect to the intent of the legislature. *Cont'l Cas. Ins. Co. v. Functional Restoration Assocs.*, 19 S.W.3d 393, 402 (Tex. 2000) (citing *Liberty Mut. Ins. Co. v. Garrison*

Contractors, Inc., 966 S.W.2d 482, 484 (Tex.1998)); *R.R. Comm'n of Tex. v. Tex. Citizens for a Safe Future & Clean Water*, 336 S.W.3d 619, 624 (Tex. 2011); Tex. Gov't Code § 312.005. In so doing, courts look first to the plain and common meaning of the statute's words. *See id.*; *Fitzgerald v. Advanced Spine Fixation Sys., Inc.*, 996 S.W.2d 864, 865 (Tex.1999). Courts will consider the entire statute, not simply the disputed portions. *State v. Terrell*, 588 S.W.2d 784, 786 (Tex.1979). Each provision must be construed in the context of the entire statute of which it is a part. *Bridgestone/Firestone, Inc. v. Glyn-Jones*, 878 S.W.2d 132, 133 (Tex.1994) ("Only in the context of the remainder of the statute can the true meaning of a single provision be made clear.").

The Code Construction Act, Government Code chapter 311, provides additional guidelines for statutory interpretation. For instance, words and phrases should be read in context, not in isolation. Tex. Gov't Code § 311.011(a). Words and phrases that have acquired a technical or particular meaning shall be construed accordingly. *Id.*, § 311.011(b). The entire statute is intended to be effective. *Id.*, § 311.021(2). A just and reasonable result is intended; one that is feasible of execution. *Id.*, §§ 311.021(3) and (4). The public interest is favored over any private interest. *Id.*, § 311.021(5).

In construing a statute a court may consider: (1) the object sought to be obtained; (2) the consequences of a particular construction; and (3) an agency's construction of a statute that is committed to the agency for enforcement. *Id.*, § 311.023(1), (5) and (6).

These same principles apply to construction of an agency's rules and policies. *See. e.g., Southwest Pharm. Solutions, Inc., v. Tex. HHSC*, 408 S.W.3d 549, 2013 Tex. App. LEXIS 8600, at *17-18 (Tex.App.—Austin 2013, pet. filed); *Boswell v. Brazos*

Electric Power, 910 S.W.2d 593, 599-600 (Tex. App.—Fort Worth 1995, writ denied); Tex. Gov't Code § 311.002(4).

In the context of an agency's consideration of a PFD, the agency decision maker sits in the role of the judge. When an ALJ opines on the meaning of agency policy, that pronouncement is merely the ALJ's interpretation, which the final agency decision maker is free to disregard. *Thompson*, 2013 WL 3791486, at *6 ("An agency enjoys ***complete discretion*** in modifying an ALJ's findings and conclusions when those findings and conclusions reflect a lack of understanding or misapplication of the existing laws, rules, or policies."), citing *Montemayor*, 2003 Tex. App. LEXIS 5099, at *26-27.

The ALJs' interpretation and application of Medicaid policy is a question of law that is committed to the discretion of the Executive Commissioner - not the ALJs. Thus, the Executive Commissioner is not bound to accept the ALJs' conclusions regarding Medicaid's use of the phrase "ectopic eruption." *See, e.g.*, *Froemming*, 380 S.W.3d at 792-93; *Montemayor*, 2003 Tex. App. LEXIS 5099, at *16, 26-27; *Thompson*, 2013 WL 3791486, at *6.

The Executive Commissioner therefore may, and should, decline to adopt the ALJs' and ADC's construction of Texas Medicaid policy.

First, the ALJs' erroneous determination that the TMPPM somehow includes a special definition of ectopic eruption, a definition wide open to various subjective professional opinions and capable of different interpretations in different circumstances, runs afoul of the plain language of Texas Medicaid policy, as set forth in the TMPPM and in HHSC rules, which clearly states the Medicaid orthodontia benefit is limited to

cases where the patient presents a "severe handicapping malocclusion." 25 Tex. Admin. Code § 33.71; Ex. R-15 at § 19.19. Thus, the ALJs' construction of Medicaid policy violates a fundamental requirement that law and agency policy should be construed consistently with their plain language. *Citizens for a Safe Future & Clean Water*, 336 S.W.3d at 624.

Second, the specific instruction regarding "ectopic eruption" should be construed by the Executive Commissioner in the overall context of Medicaid's limited orthodontia benefit. Tex. Gov't Code § 311.011(a). The liberal interpretation of the definition of ectopic eruption applied by the ALJs[16] is erroneous because it violates the TMPPM's clear direction that providers should be *conservative* in scoring the HLD. *See, e.g.*, Ex. R-15 at § 19.21.[17] The ALJs' construction of "ectopic eruption" in isolation from the overall context of Medicaid's policy directives also violates the requirement to consider the disputed portions of the policy within the policy as a whole. *Bridgestone/Firestone, Inc.*, 878 S.W.2d at 133.

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[16] The absurdity of the ALJs' construction of the instruction is illustrated by ADC's own expert, Dr. Orr, who testified that in his broad reading of the Manual's instruction ". . . to me, semantically it has a limitless interpretation as far as the recognition by competent dentists of teeth out of position." R.R., Vol. 2, 148:23-149:2. The ALJs' interpretation of the instruction also renders the word "unusual" in the instruction meaningless, a result that violates canons of statutory construction. *See, e.g., TGS-NOPEC Geophysical Co. v. Combs*, 340 S.W.3d 432, 439 (Tex. 2011) ("We presume that the Legislature chooses a statute's language with care, including each word chosen for a purpose, while purposefully omitting words not chosen."). As Dr. Tadlock testified, based on medical literature, nearly 80 percent of the population has teeth that are crooked to some degree, and therefore there is nothing "unusual" for teeth to erupt in a manner that is not straight or ideal. R.R., Vol. 1, at 157.

[17] The idea that HHSC would eviscerate Medicaid orthodontic policy and regulatory benefit limitations by promulgating a new and more liberal definition of a widely understood term – one of eight on the HLD index – is, at best counterintuitive. At worst, the notion is absurd.

Third, the ALJs' construction of Medicaid policy violates several additional tenets of statutory construction in the Code Construction Act:

- The ALJs ignore the meaning of ectopic eruption that is generally understood in the dental profession, in violation of Tex. Gov't Code § 311.011(b);
- The ALJs' broad interpretation of ectopic eruption renders the limiting language in State regulations (e.g., 25 Tex. Admin. Code § 33.71) and in Medicaid policy (*e.g.* Ex. R-15, at § 19.19) ineffective, in violation of Tex. Gov't Code § 311.021(2);
- The ALJs' interpretation leads inevitably to an "ectopic eruption in the eye of the beholder" standard, which is absurd given scarce Medicaid resources and HHSC statements regarding the limited nature of the orthodontic benefit. Opening the definition to the subjective interpretation of providers also deprives Medicaid policy makers of their statutory and regulatory responsibility for defining the scope of the benefit. Thus the ALJs' interpretation violates Tex. Gov't Code § 311.021(3) (a just and reasonable result is intended), and Tex. Gov't Code § 311.021(4) (a result feasible of execution is intended);
- The ALJs' construction favors only the private pecuniary interests of unscrupulous providers, at the expense of taxpayers and truly eligible Medicaid recipients. Thus the ALJs' interpretation violates Tex. Gov't Code § 311.021(5) (public interest is favored over any private interest);
- The ALJs failed to consider the purposes of Medicaid policy: their construction does not advance the goal of preserving scarce Medicaid dollars by limiting orthodontic reimbursements to cases of severe handicapping malocclusion. Thus it violates Tex. Gov't Code § 311.023(1); and
- The ALJs failed to consider the consequences of their interpretation. Under their interpretation, any provider's PA request for comprehensive orthodontia will be approved, so long as the provider scores the HLD with a 26 or greater – without regard to the true condition of the patient. This has far reaching implications for the Medicaid program, particularly in light of the ALJs' acknowledgement (proposed FoF No. 25) that HHSC's Medicaid claims processing contractor, TMHP, abrogated its responsibility to review clinical data submitted with PA requests. The ALJs' interpretation violates Tex. Gov't Code § 311.023(5).

Finally, the ALJs' interpretation of the Medicaid meaning of ectopic eruption is contrary to the agency's long-held and consistent construction of the phrase and should therefore be rejected. *Southwest Pharm.*, 408 S.W.3d at *17-18 ("[W]e must uphold an enforcing agency's construction if it is reasonable and in harmony with the statute . . . This deference is particularly important in construing a complex statutory scheme like Medicaid."), citing *R.R. Comm'n of Tex. v. Tex. Citizens for a Safe Future and Clean Water*, 336 S.W.3d 619, 624 (Tex. 2011) (court will defer to agency's long-standing construction of statute that is committed to agency for enforcement, as long as the interpretation is reasonable and not contrary to the statute's plain language). *See also Atascosa Cnty. v. Atascosa Cnty. Appraisal Dist.*, 990 S.W. 2d 255, 258 (Tex. 1999) (courts may not accept interpretations of a statute that defeat the purpose of the legislation so long as another reasonable interpretation exists); Tex. Gov't Code § 311.023(6).

Southwest Pharmacy is particularly instructive regarding this point. The plaintiff pharmacy providers challenged HHSC rules pertaining to pharmacy reimbursements under Medicaid's managed care program. The outcome of the dispute turned, in part, on construction of the phrase "medical assistance" as defined in Government Code chapter 531, Human Resources Code chapter 32, and the rules adopted thereunder. *Southwest Pharm.*, 408 S.W.3d at *19-20. In siding with HHSC, the court noted that the disputed statutory language must not be read in isolation, but rather, must be analyzed "in the context of the statutes as a whole." 408 S.W.3d at *27. "We must consider the role of the provisions in the full Medicaid statutory scheme and in . . . context. . . And we must

construe the provisions in a way that is consistent with their underlying purpose and the policies they are intended to promote." *Id.* The court further noted:

> Even if we were to conclude that there is vagueness, ambiguity, or room for policy determinations in these statute and rules, we would conclude that HHSC's interpretation of the relevant code provisions and agency rules is reasonable, in harmony with the statutes and rules, and entitled to deference. *See Texas Citizens, 336 S.W.3d at 629.* We defer to the agency's interpretation unless it is plainly erroneous or inconsistent with the language of the statute or rule. *See TGS-NOPEC Geophysical Co., 340 S.W.3d at 438.* As the agency designated to administer Medicaid, HHSC is charged with overseeing a complex regulatory scheme, and deference to its construction is particularly important. *See Texas Citizens, 336 S.W.3d at 629.* An agency's construction does not have to be "the only--or the best--interpretation in order to warrant . . .deference." *Id. at 628.* Considering the entire statutory scheme, the goals and policies behind it, and the legislative history and intent, we would conclude that HHSC's interpretation is reasonable, does not conflict with the provisions' language, and is entitled to deference.

Id. at *29-30 (emphasis added).

Rather than concluding that the definition of ectopic eruption is open to subjective interpretation, the ALJs should have adopted the agency's own construction, as presented by agency staff witnesses and by the Inspector General's testifying expert.[18] The record presented by agency staff witnesses and disinterested experts shows that the TMPPM's

[18] The ALJs state Dr. Tadlock, an Associate Clinical Professor at the Baylor College of Dentistry, "assisted" in scoring Medicaid patients at Baylor and state "he has no Medicaid patients of his own" to discount his testimony. PFD at 24, In doing so, the ALJs disregard evidence: (1) Dr. Tadlock has treated, and supervised treatment by orthodontic residents, of Medicaid patients, (2) has reviewed several hundred HLD score sheets. R.R. Vol. 1, at 131:16-23 (stating the faculty makes diagnostic and treatment decisions and treat patients "with the students"). Also, the ALJs apparently ignore the fact Dr. Tadlock is the only board-certified orthodontist who testified in this case; in fact, he is one of only eight directors nationally of the American Board of Orthodontists and is the incoming Chair of the ABO clinical committee, which administers the clinical exam to orthodontic residents nationally. R.R. Vol. 1, at 133:10-134:20.

instruction regarding ectopic eruption is not vague and is in fact consistent with the widely recognized understanding of ectopic eruption in the dental community. *See* R.R., Vol.1, 236:3-15 (Dr. Tadlock testifying that the definition of ectopic eruption is learned at every dental school and in every orthodontic program in the country);[19] *see also* R.R.,Vol. 2 at 84:23-24 (Dr. Orr acknowledging that "ectopic" means "out of place," and that this meaning is found "in medicine all over.").

The Inspector General's (and HHSC's) understanding of the meaning of ectopic eruption is reasonable, and is consistent with Medicaid policy and applicable laws. Therefore, it is entitled to deference. *Southwest Pharm.*, 408 S.W.3d at *29-30.

The record also reflects HHSC's long-standing requirement that medical and dental terms should be interpreted for Medicaid purposes just as those terms are construed by practitioners for their non-Medicaid patients. Ex. R-14, (2008 TMPPM) at §1.2.5; Ex. R-15 (2009 TMPPM), at § 1.4.5; RR, Vol. 1, 93:2-9; 94:16-23;111:11-14; RR, Vol. 3, 193:5-194:1; 241:5-11; 249:11-250:19.

Dr. Tadlock's expert testimony that ectopic eruption is generally understood within the dental and orthodontic profession as a "tooth that is out of place," is not only

[19] The ALJs appear to conclude Dr. Tadlock relied exclusively on the Proffit textbook in defining "ectopic eruption." PFD, at 17. While the Proffitt textbook is certainly a generally-accepted textbook, Dr. Tadlock also testified regarding his review of medical literature, including nearly 1,300 articles discussing "ectopic eruption." R.R. Vol. 1, at 152:1-154:11. As Dr. Tadlock noted, discussing medical and scientific literature back to 1938, "The bottom line is this, there are no references to teeth that are rotated or tipped. There *are -- ectopic eruption in every article is a tooth that is away from, it is out of place, it is in the wrong place.* Not most of them, many of -- not most of them, all of them." Id. at 153:1-6 (emphasis added); see also 154:4-11 ("*But in every case, they are teeth that are out of the position,* they are not here in turn; they are out, they are somewhere else. *That's the definition of ectopic eruption that existed that started in 1938 or somewhere before then. It has existed in its same form since then, up to '87 when Dr. Proffit wrote its eruption in the wrong place, and that definition has not changed.*")(emphasis added).

supported by the medical literature and the testimony of the State's Medicaid policy witness, Dr. Altenhoff, it is also the *only* competent expert testimony of record.[20] *See generally*, Dr. Tadlock's testimony at RR, Vol. 1, at 152:1-154:11; *see also* R.R., Vol. 3, 240:22-241:4 (Mr. Stick testifying that Dr. Altenhoff is the person most knowledgeable about Medicaid policy), and Vol. 3, 174:19-175:7 (Dr. Kanaan acknowledging that Dr. Altenhoff is the expert on what Medicaid covers and does not cover).[21]

The ALJs' error in disregarding the testimony of Drs. Tadlock and Altenhoff is magnified because they misconstrue what Dr. Kanaan actually said. The ALJs incorrectly assert that Dr. Kanaan concluded that Patients 36, 37, 42, 43, and 47 each presented a "severe handicapping malocclusion." *See* PFD at 26-27. This statement is not supported by the evidentiary record. Out of these patients, the only ones for which Dr. Kanaan made such as statement were Patients 36 and 47. R.R. Vol. 3, at 149:3-4 (describing Patient 36 as a "100 percent dysfunctional handicapping case"); R.R. Vol. 3, at 161:23 – 162:6 (opining that Patient 47 presented "dental necessity, medical necessity, hundred -- hundred percent handicap malocclusion"). For each of the other patients, Dr. Kanaan

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[20] At pages 18-19 of the PFD, the ALJs discuss other alleged differences between the Medicaid Manual and the general (i.e., non-Medicaid) practice of orthodontics. *See* PFD, at 18-19. The ALJs' analysis is flawed because the ALJs rely on excerpts from decades-old articles by Draker (R-37, published in 1958), Parker (P-84, published in 1998), and Andrews (P-83, published in 1972), none of which were admitted into evidence for the truth of the matter. *See, e.g.*, PFD at 19, fn. 101. Moreover, many of the "differences" relate to the measurement of a condition for the purposes of limiting Medicaid eligibility, e.g., open bite, anterior crowding, exclusion of posterior teeth for the purposes of scoring (as opposed to defining) ectopic eruption, not the creation of a Medicaid-only definition for these conditions that expands eligibility far beyond the commonly-recognized meaning of these terms.

[21] When asked by Judge Seitzman if conditions would qualify as ectopic eruption after the January 2012 clarifying amendment, Dr. Kanaan answered: "You would need to ask Dr. Altenhoff." RR, Vol. 3, 174:19-175:4.

merely stated that the patient, in his opinion, needed orthodontic treatment. R.R. Vol. 3, at 156:16-19 (Patient 37)(answering "100 percent, 120 percent" when asked patient had a "true orthodontic need"); R.R. Vol. 3, at 155:1-6 (Patient 42)(answering "correct, hundred percent" when asked if case was an example of "true orthodontic need"); R.R. Vol. 3, at 159:12-16 (Patient 43)(agreeing that the patient had a "true orthodontic need for braces"). This distinction is more than a semantic one, as the standard for Medicaid coverage is "severe handicapping malocclusion" and not merely "true orthodontic need." *See* 25 Tex. Admin. Code § 33.71.

B. ALJs' erroneous interpretation of Medicaid policy and disregard of HHSC's intent resulted in misinterpretation of fact and expert testimony.

Had the ALJs not misinterpreted Medicaid policies and ignored HHSC's clear intent as expressed in both rule and in the TMPPM, they would have found sufficient evidence of fraud or willful misrepresentation.

1. The evidence presented shows patterns of fraud.

Instead, the ALJs erroneously dismissed the evidence and concluded ADC did not commit fraud or make willful misrepresentations. For example, Dr. Kanaan's scoring pattern shows reliable evidence of fraud: he scored 27 of the 63 patients in the sample. Of those 27 patients, Dr. Kannaan scored 23 (85%) as having the *same eight teeth ectopic*. R-83; R.R. Vol. 3 at 46-70, 96-97. The rate of occurrence of ectopic eruption in the cases scored by Dr. Kanaan flies in the face of expert testimony that, according to the scientific literature, ectopic eruption is rare and the incidence of even one tooth ectopic

occurs only in between 1.5 and 9 percent of the population.[22] Although the ALJs make passing note of Dr. Kanaan's scoring pattern, they fail to draw any inferences from this objectively observed conduct, nor do they explain how this evidence relates to the Inspector General's burden to continue the payment hold.[23] *See* 42 C.F.R. § 455.2 (a Medicaid agency may receive credible allegations of fraud from any source, including "patterns identified through provider audits.").[24]

Additionally, the Inspector General presented reliable evidence that ADC submitted to Medicaid for payment fraudulently scored HLD scores sheets for 61 of the 63 patients in the sample and that these 61 patients had six or more ectopically-erupted teeth. In light of the commonly understood meaning of ectopic eruption as established by the testimony of Dr. Tadlock and Dr. Altenhoff, the egregiousness of ADC's scoring pattern shows reliable evidence of fraud or willful misrepresentations and satisfies the

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[22] Dr. Kanaan testified the ectopic eruption is so rare that he has never treated a private-pay patient for a single ectopically-erupted tooth. R.R.,Vol. 3 at 96:6-9. Yet, he also testified that he does not diagnose Medicaid and private-pay patients differently. *Id.* at 17:22-25. Dr. Kanaan even testified that the very same mouth that has ectopically-erupted teeth for Medicaid purposes is a prime example – the very example he uses on his other practice's website – of crowding. R.R.,Vol. 3 at 20:25-21:1 (the photo on his website is an example of crowding), 21:5-20 (explaining that the photo is of ADC's Medicaid patient), 25:5-25:8 (stating that he scored this patient as ectopic). He nevertheless scored each of his patients in the sample as having 7 or more ectopic teeth. This testimony, despite his protestations to the contrary, demonstrates that Dr. Kanaan scores his private pay patients one way and his Medicaid patients completely differently.

[23] Indeed, not a single one of the patients in the sample was eligible for Medicaid-covered comprehensive orthodontics without ADC's score for ectopic eruption: excluding those ectopic eruption scores, ADC's sample HLD scores ranged from 0 (9 patients) to 19 (1 patient). Further, even assuming that each of these patients had not one, but two instances of the very rare phenomena of ectopic eruption in their anterior teeth, they still would not have been eligible for Medicaid-covered comprehensive orthodontics, as they could not achieve the qualifying score of 26.

[24] As noted throughout these Exceptions, the evidentiary burden on the Inspector General in this proceeding is not particularly onerous. The evidence must have "indicia of reliability." In other words, it is reliable unless rebutted and shown to be immaterial, untrue, inaccurate or unreliable.

Inspector General's burden to maintain the payment hold. Tex. Gov't Code § 531.102(g)(2).

2. The Inspector General's experts' testimony confirms that ADC's conduct was fraudulent or willfully misrepresentative.

The ALJs expressly decline to rely on ADC's proffered experts, Orr and Ornish, for their determinations regarding ectopic eruption. PFD at 28. Instead the ALJs attempt to refute Dr. Tadlock's expert testimony by citing to the testimony of Drs. Nazari and Kanaan. However, ADC did not proffer either Dr. Nazari or Dr. Kanaan as an expert in this hearing. See, *Petitioner's Expert Designations* [Docket #32] (listing only Dr. Orr and Dr. Ornish). The ALJs also fail to note in their PFD Dr. Nazari's testimony that he learned how to score the HLD index "for Medicaid" from Dr. Orr. R.R.,Vol. 4 at 137:17-25.[25] Thus, even though the ALJs putatively do not rely on Orr and Ornish, their reliance on Dr. Nazari is misplaced because his opinions are entirely derivative of Dr. Orr – a demonstrably unreliable and incompetent expert.[26] The ALJs thus erred by relying on

[25] Dr. Nazari testified the methodology he applied for ectopic eruption was to include any teeth that were "rotated, the slanted leaning teeth" based on what he learned from Dr. Orr a decade prior. R.R., Vol. 4, at 102:22-103:4, 138:18-23 (including any teeth that are "twisted or turned or crooked"). This description, however, does not comport with either the generally-accepted scientific understanding of the term "ectopic eruption" or in the instruction of the TMPPM which refers to "an unusual pattern of eruption."

[26] On page 28 of the PFD, the ALJs summarily state that the HLD scores of Dr. Orr and Dr. Ornish, ADC's experts, were "generally similar" to ADC's scores and that their testimony was "cumulative" of the testimony of Drs. Nazari and Ornish; accordingly, the ALJs state they did not rely upon the testimony of either Dr. Orr or Dr. Ornish. The Inspector General objects to this cursory treatment of ADC's experts for two reasons. First, the evidence shows Dr. Nazari's understanding of HLD score sheets was directly based on training he received from Dr. Orr. R.R. Vol. 4, at 137-38 (testifying that he learned the theory that "ectopic eruption means any tooth that is twisted or turned or crooked" from Dr. Orr). It is therefore impossible to evaluate Dr. Nazari's credibility, particularly with regard to his use of the HLD score sheet, without addressing or relying on Dr. Orr's credibility, which was unquestionably undermined by his live

providers for their interpretation of Medicaid policy, and by disregarding the testimony of Medicaid policy witnesses and qualified experts. *See Southwest Pharm.*, 408 S.W.3d at *29.

C. The January 2012 amendment to the TMPPM was a clarification of existing Medicaid policy, not a substantive change.

The ALJs similarly erred by failing to find that the January 2012 amendment to the TMPPM's instruction regarding ectopic eruption was intended to clarify what was always Texas Medicaid policy. Although their PFD does not address this point directly, the ALJs did not apply the January 2012 clarification in their analysis of the factual record in this case. The ALJs implicitly, and impermissibly, conclude that the January 2012 amendment was a substantive change that does not apply to the conduct at issue.[27]

Once again, the ALJs misunderstand and misapply Medicaid policy. Dr. Linda Altenhoff, who was acknowledged even by ADC to be the witness most knowledgeable about Medicaid policy testified that the January 2012 change to the TMPPM's instruction was a clarifying amendment, not a substantive change in policy. R.R., Vol, 1 at 93:2-9, 94:16-23. Jack Stick, the Deputy Inspector General for Enforcement, also testified that the January 2012 change clarified existing policy. R.R.,Vol. 3 at 193:5-194:1; 294:21-23.

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testimony in this case. See also Respondent's Closing Brief at 13, 33-37. Second, it is factually incorrect to conclude that Dr. Ornish's scores were "generally similar" to ADC – in fact, Dr. Ornish, the only expert orthodontist retained by ADC, scored 13 of the 63 ADC patients as having an HLD score less than 26, meaning own ADC's expert opined that nearly 21 percent of the ADC patients did not qualify for Medicaid based on the HLD score.

[27] On page 20, at FN 105, the ALJs write that prior to the 2012 amendments Medicaid policy did not restrict the "definition" of ectopic eruption to exclude teeth that are rotated, slanted or leaning.

The ALJs' failure to apply the clarifying instruction in their interpretation of the meaning of ectopic eruption and in their analysis of the evidence of record is a legal error that must be corrected by the Executive Commissioner.

D. The ALJs erred in relying on the Harlingen Family Dentistry decision, which was wrongly decided and should be changed.

To the extent the ALJs relied on *Harlingen Family Dental*, which was wrongly decided and should be changed, the ALJs' PFD should be changed or ignored. *See* Tex. Gov't Code 2001.058(e)(2). The ALJs impermissibly accord no weight to Dr. Evans, the Inspector General's initial reviewing expert. PFD at 24. To the extent that the ALJs' analysis of Dr. Evans's credibility and qualifications rests on the *Harlingen Family Dental*[28] decision, it is erroneous. The ALJs cite verbatim and thus appear to rely on, and adopt as their own, four findings from Harlingen: FoF Nos. 29, 31, 33, and 34. *See* PFD at 23-24. The *Harlingen* findings are, respectively, that: Dr. Evans did not treat Medicaid patients and was not familiar with the HLD index (*Harlingen* FoF No. 29); Texas Medicaid has for years paid for orthodontic benefits using a definition that is more expansive than that used by Dr. Evans (*Harlingen* FoF No. 31); Dr. Evans's scoring lacks credibility, reliability and indicia of reliability (*Harlingen* FoF No. 33); and there was no indicia of reliability regarding the 85 *Harlingen* patients Dr. Evans reviewed (*Harlingen* FoF No. 34). *Id.* That the ALJs included any mention of *Harlingen*, particularly a verbatim recitation of four findings of facts after opining, wrongly, that the Inspector

[28] *Harlingen Family Dentistry v. Texas Health and Human Services Commission, Office of Inspector General*, SOAH Docket No. 529-12-3180. Final HHSC Order issued on October 10, 2012.

General relied solely on Dr. Evans when deciding to impose a payment hold, PFD at 23, strongly implies the ALJs employed an inappropriate analysis – using facts from another case, and a wrongly decided case at that. Tex. Gov't Code § 2001.058(e)(2).

Harlingen FoF No.29 is irrelevant for the reason discussed at length above. There are not two standards of care: one for the population at large, the other for Medicaid patients. Thus, the fact that Dr. Evans did not treat Medicaid patients is of no consequence in either the *Harlingen* case, or in this matter. That the ALJ in *Harlingen* discredited Dr. Evans because he did not treat Medicaid patients, is, therefore error. In relying on, and implicitly adopting this finding as their own, the ALJs in this case have compounded the error.

Harlingen FoF Nos. 31 and 33 suffer from the same misapplication of law and Medicaid policy that is present in this case. Finding of Fact No. 31 erroneously states that Texas has "for decades" employed a different standard for determining ectopic eruption in the Medicaid population than the standard that is applicable to the general population. This flawed finding is premised on a misapplication of law, for the reasons described earlier: the same standards of care that apply in the general population must by federal law, state law, Medicaid policy and common decency also apply to the Medicaid population. Ex. R-16, at § 1.6; Ex. R-15, § 19.2; *see also* R.R., Vol. 1, 109:25-110:9.[29]

[29] In fact, *Harlingen* FoF No. 31's statement that "for decades," Texas Medicaid employed a more expansive definition of ectopic eruption is itself a misstatement of the evidence in that case. The *Harlingen* decision relies upon Dr. Orr's testimony that "Dr. Evans had used "the two examples of ectopic eruption rather than the decades old rule that frankly everyone in the world uses." *Harlingen PFD*, at 18 (emphasis added). Of course, Dr. Orr was erroneously relied upon as the former "Texas Medicaid Director" based on his misrepresentation to the tribunal when in fact he was employed by the

Likewise, *Harlingen* FoF No. 33 is also flawed because the ALJs mistakenly presume Dr. Evans applied the wrong standard to his scoring of the *Harlingen* sample. To the extent that the ALJs in this case impermissibly rely on the *Harlingen* findings as a basis to discredit Dr. Evans in this case, they have committed reversible error.[30]

Further, the ALJ's reliance on discrediting Dr. Evans is itself a red herring. Even if it was true Dr. Evans's assessment in *Harlingen* could not be relied upon, the ALJs in this matter have ignored the fact that Dr. Evans's testimony and conclusions were supported in the ADC case by Dr. Altenhoff and by Dr. Tadlock, who by any measure is a recognized expert and scholar in the orthodontic field. Even more significantly, *Dr. Evans was not the only basis for the Inspector General's payment hold.* Discrediting Dr. Evans – correctly or not – cannot impact the validity of whether the Inspector General had a verified and credible allegation of fraud.

IV. BECAUSE OF THE ALJs' MISAPPLICATION AND MISINTERPRETATION OF LAW, AGENCY RULES, AND HHSC MEDICAID POLICY, THE EXECUTIVE COMMISSIONER SHOULD, AS IS HIS RIGHT UNDER SECTION 2001.058(e), MODIFY THE PFD'S FINDINGS OF FACT AND CONCLUSIONS OF LAW AND REJECT THE PROPOSED RECOMMENDATION

The ALJs' errors in the application of law and Texas Medicaid policy resulted in legally objectionable and erroneous proposed findings of fact (FoF) and conclusions of

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National Heritage Insurance Company from 1995 to 2004, and never had a role in implementing Medicaid policies relating to orthodontics. Inspector General's Closing Brief at 34.

[30] The ALJs' reliance on Judge Kilgore's findings in *Harlingen* is curious, given their rejection of ADC's collateral estoppel and res judicata arguments. PFD at 2.

law (CoL) in the PFD. The Inspector General specifically excepts to certain findings and conclusions and urges the Executive Commissioner to modify the PFD as follows:

1. Proposed FoF No. 10 states: *According to the Manual, the intent of the Medicaid orthodontia program was to provide orthodontic care to clients 20 years of age or younger with severe handicapping malocclusion to improve function.*

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

   The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 10 and replace it with final FoF No. 10: **Medicaid orthodontia services are limited to treatment of children aged 12 to 20 with severe handicapping malocclusions and other related conditions, unless an exemption is expressly sought by the provider.**

2. Proposed FoF No. 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. *See State v. Durham*, 860 S.W.2d 63, 67 (Tex. 1993). The proposed finding ignores the responsibility ADC had to submit truthful documentation to the State (including the responsibility expressly stated in the Provider Agreement and agreed to by ADC and/or its providers), including accurate HLD scoresheets 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." *Id.*

   The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 21 and replace it with final 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 scoresheets and PA requests substantiating the patient's condition as meeting Medicaid's requirements.**

3. Proposed FoF No. 23 states: *After ADC provided the orthodontic treatment to the patients in this case, TMHP approved payment.*

Proposed FoF No. 23 misstates the facts on the record and assumes facts not in evidence. Proposed FoF No. 23 erroneously assumes that ADC actually provided treatment (which was not at issue at the payment hold hearing, and no proof, therefore, has been marshaled or established as true, as would be required by the Texas Rules of Evidence, establishing that ADC ever, in fact, provided the treatment detailed in the PAs to the 63 patients in the sample). Proposed FoF No. 23 is also irrelevant (even if it were proved true), because the issue is the falsity of ADC's scoring of the HLD scoresheets, Not whether ADC actually performed treatment (which, if it ever did become an issue, would probably also be proved untrue due to the underlying fraudulent scoring of the scoresheets).

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 23.

4. 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. *See State v. Durham*, 860 S.W.2d at 67. The proposed finding ignores the responsibility ADC had to submit truthful documentation to the State, including accurate HLD scoresheets 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." *Id.*

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 26 and replace it with final 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.**

5. 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 scoresheets and represented to the State the accuracy of the scores. Also, Dr. Nazari is not an orthodontist.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 29 and replace it with final FoF No. 29: **The HLD score sheets 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."**

6. Proposed FoF No. 39 states: *The Manual's definition of ectopic eruption in the 2008 through 2011 Manual required subjective judgment to interpret.*

   Proposed FoF No. 39 is erroneous because (i) the TMPPM's discussion of ectopic eruption is an instruction, not a medical definition, as discussed above; (ii) the ALJ's determination that ectopic eruption is open to subjective interpretation disregards accepted standards within the orthodontic profession. These errors reflect a misinterpretation of law and policy by the ALJs.

   Proposed FoF No. 39 addresses a mixed question of fact and law, and is a so-called "legislative finding."[31] Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

   The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 39 and replace it with final FoF No. 39: **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.**

7. Proposed FoF No. 40 states: *The Manual's definition of ectopic eruption was amended, effective January 1, 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.*

[31] A "legislative fact" is a mixed question of fact and law and defining terms is an agency function. F. Scott McCown & Monica Leo, *When Can an Agency Change the Findings of Conclusions of an ALJ?: Part Two*, 51 Baylor L. Rev. 63, 69-70 (1999).

Proposed FoF No. 40 is erroneous because (i) the TMPPM's discussion of ectopic eruption is a scoring instruction, not a definition, as discussed above; and (ii) the proposed FoF misleadingly suggests that the 2012 amendment was substantive and not clarifying. The 2012 amendment to the instructions in the TMPPM clarified existing Medicaid policy. It did not effect a substantive change. R.R., Vol, 1 at 93:2-9, 94:20-23 (Dr. Altenhoff), R.R.,Vol. 3 at 193:18-194:1; 294:21-23 (Jack Stick).These errors reflect a misinterpretation of law and policy by the ALJs.

Proposed FoF No. 40 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 40 and replace it with final FoF No. 40: **The Manual's instruction regarding ectopic eruption was amended, effective January 1, 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.**

8. 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 is erroneous because (i) the TMPPM's discussion of ectopic eruption is an instruction, not a definition, as discussed above; and (ii) the proposed finding erroneously suggests that it was Texas Medicaid policy to adopt a distinct "definition" of ectopic eruption in the TMPPM that differed from ectopic eruption as generally understood within the dental profession. These errors reflect a misinterpretation of law and policy by the ALJs.

Proposed FoF No. 41 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 41 and replace it with final FoF No. 41: **The language in the Manuals provided instructions to dentists and orthodontists to score ectopic eruption consistently with the standards for ectopic eruption that are generally recognized in the dental profession.**

9. 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 is erroneous because (i) the TMPPM's discussion of ectopic eruption is an instruction, not a definition, as discussed above; and (ii) the proposed finding erroneously suggests that it was Texas Medicaid policy to adopt a distinct "definition" of ectopic eruption in the TMPPM that differed from ectopic eruption as generally understood within the dental profession. These errors reflect a misinterpretation of law and policy by the ALJs.

   Proposed FoF No. 42 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

   The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 42 and replace it with final FoF No. 42: **The Manuals 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.**

10. Proposed FoF No. 44 states: *After reviewing the patients' HLD score sheets, Dr. Tadlock found only one patient with ectopic eruptions that scored 26 points, Patient 15.*

    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 patient 15, but zero points of that total were comprised of points for ectopic eruption. *See* 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 Inspector General recommends that the ALJs delete proposed FoF No. 40 and replace it with final FoF No. 40: **After reviewing the patients' HLD score sheets, Dr. Tadlock found one patient (Patient 15) with an HLD score of 26 points or higher.**

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

Proposed FoF No. 45 is erroneous because (i) the TMPPM's discussion of ectopic eruption is an instruction, not a definition, as discussed above; (ii) the proposed finding erroneously suggests that it was Texas Medicaid policy to adopt a distinct "definition" of ectopic eruption in the TMPPM that differed from ectopic eruption as generally understood within the dental profession; and (iii) the proposed finding misconstrues Dr. Tadlock's testimony. In fact, Dr. Tadlock's testimony shows that in his view, the Manual's instructions are consistent with the generally understood definition of ectopic eruption. R.R., Vol. 1, 202:21-203:10. These errors reflect a misinterpretation of law and policy by the ALJs, as well as a 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 Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 45 and replace it with final 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.**

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

Proposed FoF No. 46 is erroneous because (i) the TMPPM's discussion of ectopic eruption is an instruction, not a definition, as discussed above; (ii) the proposed finding erroneously suggests that it was Texas Medicaid policy to adopt a distinct "definition" of ectopic eruption in the TMPPM that differed from ectopic eruption as generally understood within the dental profession; and (iii) the proposed finding ignores evidence that directly refutes Dr. Nazari's credibility. For example, contrary to Texas Medicaid policy requirements that providers treat Medicaid patients to the same standard of care as the general population, Dr. Nazari testified that orthodontics for Medicaid patients is different than orthodontics for non-Medicaid patients. R.R., Vol. 4, 103:13-16, 104:1-4, 145:9-10. Further, Dr. Nazari was unable to define a "severe handicapping malocclusion." *Id.*,144:17-145:6. Proposed FoF No. 46 reflects a misinterpretation of law and policy by the ALJs, as well as a mischaracterization of Dr. Nazari's credibility.

Proposed FoF No. 46 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 46 and replace it with final FoF 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 were fraud or willful misrepresentations.**

13. 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 (i) the TMPPM's discussion of ectopic eruption is an instruction, not a definition, as discussed above; (ii) the proposed finding erroneously suggests that it was Texas Medicaid policy to adopt a distinct "definition" of ectopic eruption in the TMPPM that differed from ectopic eruption as generally understood within the dental profession; and (iii) the proposed finding ignores evidence that directly refutes Dr. Kanaan's credibility. For example, Dr. Kanaan testified that the word "handicapping" in the phrase "severe handicapping malocclusion" means "extreme deviation from the norm." R.R., Vol. 3, 101:3-8. Yet, 100% of the patients he treated in the statistically valid random sample exhibited severe handicapping malocclusions. *Id.*, 97:5-8. Proposed FoF No. 47 reflects a misinterpretation of law and policy by the ALJs, as well as a mischaracterization of Dr. Kanaan's credibility.

Proposed FoF No. 47 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 47 and replace it with final FoF 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 were fraud or willful misrepresentations.**

14. 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 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 their interpretation of ectopic eruption. *See e.g.* testimony of Dr. Tadlock at RR, Vol. 1, 173:3-6; 174:6-175:1; 176:14-20; 177:1-16; *see also* testimony of Dr. Nazari, RR, Vol. 4, at 144:17-145:6; and testimony of Dr. Kanaan, RR, Vol. 3, at 43-70. The totality of the evidence, which includes the testimony of ADC's own witnesses, as well as the Inspector General's experts, is much more than *prima facie*, and is relevant, credible and material. *See* Tex. Hum. Res. Code § 32.0291(c). The evidence is also reliable. The proposed finding is erroneous because implicit in it are the 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 ALJs.

Finally, this proposed FoF reflects a further misapplication of law in suggesting that the Inspector General bears the burden of proving intent to defraud Medicaid. As the ALJs acknowledge in the narrative section of their PFD, the Inspector General 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 the TMFPA. *See* PFD at 15, citing definition of "Knowingly" at section 36.0011 of the TMFPA; *see also* CoL No. 6, at page 42 of the PFD (same proposition). Nevertheless, in proposed FoF No. 48, the ALJs write that the Inspector General failed to present credible, reliable, or verifiable evidence that ADC incorrectly scored HLD indices "*to obtain Texas Medicaid benefits for patients or to obtain Texas Medicaid payments*." The burden on the Inspector General is only 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. To the extent that the ALJs attempt to hold the Inspector General to the additional burden of proving intent on the part of ADC to defraud the Medicaid program, proposed FoF No. 48 is erroneous.

Proposed FoF No. 48 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 48 and replace it with final FoF No. 48: **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.**

15. Proposed FoF No. 49 states: *There is no evidence that is credible, reliable, or verifiable, or that has indicia of reliability, that ADC committed fraud or 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 the Inspector General's burden of proof in this case. As noted in CoL No. 12, to maintain the payment hold, the Inspector General 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 ALJs' determination that the Inspector General 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 TMPPM than the generally accepted definition in the orthodontic profession; (2) that said definition was open to subjective interpretation; and (3) that the 2012 changes to the TMPPM "definition" were substantive rather than clarifying, are all errors in the application of Texas Medicaid policy and law.

Proposed FoF No. 49 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 49 and replace it with final FoF No. 49: **HHSC-OIG presented prima facie evidence that is credible, reliable, and verified, and that has indicia of reliability that ADC committed fraud or willful misrepresentations to Texas Medicaid.**

16. 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. First, the proposed finding misapplies Texas law governing the Inspector General's burden of proof in this case. As noted in CoL No. 12, to maintain the payment hold, the Inspector General 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 ALJs' determination that the Inspector General 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 TMPPM than the generally accepted definition in the orthodontic profession; (2) that said definition was open to subjective interpretation; and (3) that the 2012 changes to the TMPPM "definition" were substantive rather than clarifying, are all errors in the application of Texas Medicaid policy and law.

Proposed FoF No. 50 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 50 and replace it with final FoF 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 misrepresentations in filing requests for prior authorization with TMHP for 61 of the 63 patients in the OIG audit sample.**

17. 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 ALJs had applied the proper standard for ectopic eruption and the uncontroverted expert testimony of Dr. Tadlock to the facts of this case then 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.

Proposed FoF No. 54 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 54 and replace it with final FoF 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.**

18. Proposed FoF No. 55 states: *Patient 15, 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 ALJs use "interceptive" treatment to mean something less than comprehensive orthodontics [D8080] (and therefore outside the requirement that patients be 12 or older or have no baby teeth), the ALJs misstate the evidence. ADC billed the 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 the ALJs use "interceptive" to include code D8080, *see* Ex R-15 at § 19.19.7, they are again in error: D8080 is explicitly not applicable to patients like these who have baby teeth and are under 12 years old.

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 – D8080, or comprehensive orthodontics. The fact that ADC billed for comprehensive orthodontics when their patients did not qualify for that treatment is a program violation, and warrants a payment hold.

Specifically, with regard to Patient 15, the PFD states that ADC requested "prior authorization for interceptive treatment." PFD at 33. ADC requested D8080, comprehensive orthodontics, for this patient, even though the patient was 9 years old and had baby teeth. Ex. P-15 at P15-0019 (ADC Prior Authorization Request Form for Patient 15 requesting "D8080".) This is a program violation. 1 Tex. Admin. Code § 371.1617(1)(K) and (5)(G).

With regard to Patient 56, ADC requested D8080 comprehensive orthodontics for this patient, even though the patient was 9 years old and had baby teeth. Ex. P-56 at P56-0015 (ADC Prior Authorization Request Form for Patient 56 requesting "D8080" for a charge of $775.00.) This is a program violation. 1 Tex. Admin. Code § 371.1617(1)(K) and (5)(G).

Finally, ADC requested D8080 comprehensive orthodontics, for Patient 60 as well, even though this patient was under 12 and had baby teeth. Ex. P-60 at P60-

0004(ADC Prior Authorization Request Form for Patient 60 requesting "D8080" for a charge of $775.00.). This is a program violation. 1 Tex. Admin. Code § 371.1617(1)(K) and (5)(G).

Proposed FoF No. 55 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 55 and replace it with final FoF No. 55: **ADC committed program violations when it submitted prior authorization requests and HLD forms for D8080 comprehensive orthodontic treatment, of Patients 15, 56, 60 when these patients did not qualify for comprehensive orthodontics.**

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

Proposed FoF No. 56 misstates and misapplies testimony. Mr. Stick was asked if, generally, program violations "can fall on a continuum from the very innocuous to some that may be of greater concern, perhaps very important violations." Mr. Stick agreed to this summary. Vol. 3, 221:18-22. Mr. Stick was not commenting on the violations specific to ADC, nor was he describing any official characterization or ranking of severity of program violations as reflected in HHSC rules. The manner in which Proposed FoF No. 56 is written implies specific application or reference to ADC (particularly in light of Proposed CoL No. 16, which characterizes ADC's program violations as "innocuous").

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 56.

20. 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 Inspector General. The 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 the ALJs misapplication of Texas Medicaid policy regarding ectopic eruption. This finding is also erroneous because it is within the sound discretion of the Executive Commissioner, and not the ALJs, to determine whether ADC's record keeping violations are cause for concern, or not.

The Inspector General based its payment hold, in part, on ADC's failure to provide records pursuant to the Inspector General's request; in some cases, ADC had these records, and entered them into evidence in this case *over a year after the Inspector General requested them.* ADC's failure to provide these records *immediately* is a program violation and may result in a payment hold. 1 Tex. Admin. Code § 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."). Ex. R-15 (2009 TMPPM), § 1.4.3.

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 he Inspector General is obligated to investigate Medicaid fraud, waste, and abuse, and, in the course of investigating, is entitled to request documents of providers. Ex R-14 (2008 TMPPM) § 1.2.3; Ex. R-15 (2009 TMPPM) § 1.4.3. Furthermore, the Inspector General is entitled to base payment hold determinations on the records that Medicaid providers provide in response to a proper request on the part of the Inspector General. Medicaid providers' failure to provide documents to the Inspector General 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 the Inspector General. 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.

Proposed FoF No. 57 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.

The Inspector General recommends that the Executive Commissioner delete proposed FoF No. 57 and replace it with final FoF 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.**

21. 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 Inspector General 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." Tex. Gov't Code § 531.102(g)(2) (2011). 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 or willful misrepresentation." Tex. Hum. Res. Code § 32.0291(c) (emphasis added).

The Inspector General recommends that the Executive Commissioner delete proposed CoL No. 10 and replace it with final CoL No. 10: **The Inspector General's burden to maintain the payment hold under section 531.102(g)(2) of the Government Code or section 32.0291(c) of the Human Resources Code, is to show by reliable or *prima facie* evidence that ADC has committed fraud or made willful misrepresentations.**

22. 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."*

Proposed CoL No. 10 omits words and phrases from the statute, all essential to the meaning of the statute: "'**patterns identified through'** provider audits;" the ALJs also deleted the phrase "and law enforcement investigations" and substituted the word "is" for "may be" and "for example" for "but not limited to." Because Proposed CoL No. 10 incorrectly states the law, the Executive Commissioner 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 not limited to" for "for example."

The Inspector General recommends that the Executive Commissioner delete proposed CoL No. 10 and replace it with final CoL 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."**

23. 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.

Because CoL No. 13 rests on faulty applications of law as well as erroneous interpretations of Medicaid policy the Executive Commissioner enjoys complete discretion to correct it. *Thompson*, 2013 Tex. App. LEXIS 8832, at *6.

The Inspector General recommends that the Executive Commissioner delete proposed CoL No. 13 and replace it with final CoL 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), 371.1617(a)(1)(A)-(C), (I), (K), (2)(A), (5)(A), (5)(G) (2005).**

24. 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 been presented of fraud or willful misrepresentation. Tex. Gov't Code § 531.102(g)(2). 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 or willful misrepresentation." Tex. Hum. Res. Code § 32.0291(c) (emphasis added).

The Inspector General recommends that the Executive Commissioner delete proposed CoL No. 14 and replace it with final CoL 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).**

25. 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 also a program violation; (2) failure to provide records to HHSC-OIG is neither a technical violation nor innocuous, as 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.

Because CoL No. 16 rests on faulty applications of law as well as erroneous interpretations of Medicaid policy the Executive Commissioner enjoys complete discretion to correct it. *Thompson*, 2013 Tex. App. LEXIS 8832, at *6.

The Inspector General recommends that the Executive Commissioner delete proposed CoL No. 16 and replace it with final CoL No. 16: **ADC's failure to immediately provide HHSC-OIG with the documents and other items requested in writing is a significant program violation that, along with the extensive and overwhelming pattern of willful misrepresentations or fraud in ADC's HLD scoresheets, 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.**

V. THE EXECUTIVE COMMISSIONER SHOULD MAINTAIN A PAYMENT HOLD UNTIL THE CONCLUSION OF THE OVERPAYMENT PROCEEDING

Because the ALJs' erred in the application of Texas Medicaid policy to the facts of this case, the proposed recommendation ought to be rejected, and the Executive Commissioner should maintain a payment hold against ADC. Indeed, the PFD still concludes that the Inspector General presented *prima facie* evidence that ADC has committed record keeping violations of Medicaid requirements. PFD at 41, proposed FoF Nos. 51 and 53. The Executive Commissioner is free, therefore, to disregard proposed FoF No. 57 (the ALJs erroneously concluded that ADC's violations are nonetheless innocuous and do not justify imposition of a payment hold), and he is also

authorized to impose the just sanction of maintaining the payment hold, thus disregarding the ALJs' ultimate, and erroneous, proposed recommendation that the entire payment hold in this case be lifted. *See. e.g.*, *Froemming*, 380 S.W.3d at 792-93 (rejecting recommendation and imposing stricter sanctions); *Riley*, 315 S.W.3d at 137 (same); *Bass*, 366 S.W.3d at 755-56 (same); *Gomez*, 354 S.W.3d at 910-11 (same); *Smith v. Montemayor*, 2003 Tex. App. LEXIS 5099, at *24 (same); *Grotti*, 2005 Tex. App. LEXIS 8279, at *9, *28 (same); *Thompson*, 2013 WL 3791486, at *7 (same).

The Executive Commissioner should find that the Inspector General has met his burden of presenting *prima facie* evidence of fraud or willful misrepresentations in this case. Accordingly, the Inspector General asks the Executive Commissioner to order that the 100% payment hold remain in place pending hearing on the merits in the overpayment case.

However, even in the absence of *prima facie* evidence of fraud, a 100% hold is justified. The record of this proceeding reflects that ADC is currently the subject of at least two other investigations based on discrete facts and circumstances. RR, Vol. 3, 194:7-195:6. In light of ADC's history of alleged non-compliance with Texas Medicaid requirements, the Inspector General urges the Executive Commissioner to conclude that ADC's errors in its PA requests and its program violations are not merely innocuous, but rather cause for serious concern. Moreover, as a matter of law, the ALJs have misapplied Texas Medicaid policy regarding what does, and what does not qualify as a "severe handicapping malocclusion." Therefore, ADC has caused Texas Medicaid to pay millions of dollars in reimbursements for orthodontic services that do not qualify. The

actual overpayment recovery hearing will be at some date in the future, at which time, the Inspector General will show the precise amount of overpayment. The Inspector General is entitled to recover for the Medicaid program the amount of the overpayment regardless whether a provider's error is the result of fraud, or merely an innocent mistake. 1 Tex. Admin. Code § 371.1703(a).

Thus, even if ADC lacked the requisite mental state to commit an unlawful act when it submitted its requests for PA,[32] if Texas Medicaid paid for services that do not qualify as a matter of law for reimbursement, then the Inspector General is entitled to recover those overpayments. 1 Tex. Admin. Code § 371.1703(a). The amount held by the Inspector General may be used, in part, to off-set any amount owed to recoup overpayments. *Id.* Accordingly, the Executive Commissioner should order the Inspector General to maintain the payment hold to satisfy a potential recoupment.[33]

VI. CONCLUSION & PRAYER

WHEREFORE, PREMISES CONSIDERED, the Inspector General prays that the Executive Commissioner decline to adopt the recommendations of the ALJs' PFD. Instead, the Inspector General requests the Executive Commissioner to order that the

[32] *I.e.*, if the Executive Commissioner determines that the Inspector General failed to present *prima facie* evidence that ADC acted with knowledge of the truth or falsity of its representations to Medicaid; with conscious indifference to the truth or falsity of its representations to Medicaid; or with reckless disregard of the truth or falsity of its representations to Medicaid. Tex. Hum. Res. Code § 36.011 (defining "knowingly" for purpose of TMFPA).

[33] In the event that the Executive Commissioner orders the Inspector General to reduce the current payment hold, the Inspector General requests that the Order specify that the Inspector General retain all amounts currently held subject to the pending payment hold. 1 Tex. Admin. Code § 371.1709(d)(2)(2012).

100% payment hold remain in full force. The Inspector General prays for such other and further relief to which he is entitled.

A proposed Order is attached with these Exceptions.

Respectfully submitted,

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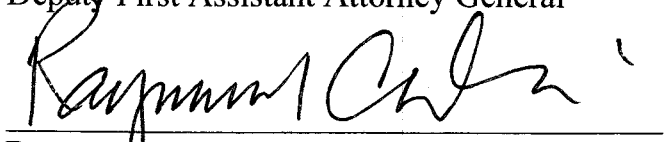

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ATTORNEYS FOR THE INSPECTOR GENERAL

CERTIFICATE OF SERVICE

I hereby certify that on this, the 22nd day of November, 2013, a true and correct copy of this Inspector General's Exceptions to the Proposal for Decision was served on the parties listed below by facsimile and regular mail.

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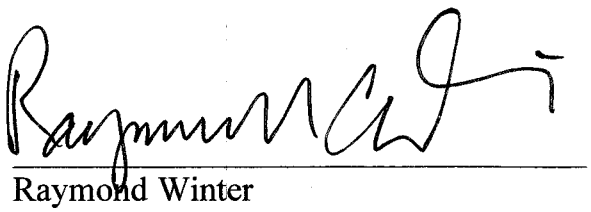

Raymond Winter

SOAH DOCKET NO. 529-13-0997
HHSC-OIG CASE NO.: P2011131652384891

ANTOINE DENTAL CENTER, *Petitioner*	§	**BEFORE THE APPEALS DIVISION**
v.	§	**OF**
TEXAS HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INSPECTOR GENERAL, *Respondent*	§	**TEXAS HEALTH AND HUMAN SERVICES COMMISSION,** **AUSTIN, TEXAS**

FINAL ORDER

On this _____ day of _____, 201_, came to be considered the above styled case before the Executive Commissioner of the Texas Health and Human Services Commission (HHSC). The Executive Commissioner considered the following items in connection with his final decision in this matter: the Proposal for Decision (PFD) issued by Administrative Law Judges (ALJs) Howard S. Seitzman and Catherine C. Egan, dated November 4, 2013; the Inspector General's Exceptions to the PFD, dated November 22, 2013; Antoine Dental Center's (ADC's) Response to the Inspector General's Exceptions; and the record of the proceedings before ALJs Seitzman and Egan. *See* Tex. Gov't Code §§ 2001.060, 2001.062.

After considering the PFD, the Inspector General's Exceptions, ADC's Response, the pleadings of the parties and the record, and in accordance with Tex. Gov't Code § 2001.058(e), the Executive Commissioner issues this Final Order.

The Executive Commissioner finds that the ALJs did not properly apply or interpret applicable Texas Medicaid policy and applicable laws governing the Medicaid program and this proceeding. Tex. Gov't Code § 2001.058(e)(1).

Specifically, the Executive Commissioner finds that the ALJs erred in interpreting Texas Medicaid policy such that this misinterpretation would impermissibly allow Medicaid providers to apply a special interpretation to the meaning of the phrase "ectopic eruption." The ALJs' determination that "ectopic eruption" has a special meaning for the purposes of Medicaid eligibility that is different from, and more liberal than, the

interpretation of the phrase in the general practice of dentistry contravenes Texas Medicaid policy and Texas law. *See e.g.*, 25 Tex. Admin. Code § 33.71 (providing that Medicaid's orthodontia benefit is limited to cases presenting severe handicapping malocclusion); *see* 2008 TMPPM, § 1.2.5, Compliance with Federal Legislation (mandating that providers must "furnish covered Medicaid services in the same manner, to the same extent, and of the same quality as services provided to other patients"). The ALJs impermissibly disregarded the testimony of HHSC witnesses regarding the limitations of Medicaid policy, and of the Inspector General's experts regarding the meaning of "ectopic eruption." *See Southwest Pharm. Solutions, Inc. v. Tex. HHSC,* 408 S.W.3d 549, 2013 Tex. App. LEXIS 8600, at *17-18 (Tex. App.—Austin 2013, pet. filed) ("Considering the entire statutory scheme, the goals and policies behind it, we conclude that HHSC's interpretation is reasonable, does not conflict with the provision's language, and is entitled to deference.").

The Executive Commissioner further finds that the ALJs erred to the extent that they impermissibly dismissed *prima facie* evidence that satisfies the evidentiary requirements to maintain a payment hold. The Executive Commissioner finds that the Inspector General presented relevant, credible, and material evidence that ADC submitted fraudulent or willfully misrepresented prior authorization requests and claims for reimbursement; ADC submitted claims for services not reimbursable; and ADC failed to maintain or provide records as required by law.

The Executive Commissioner further finds that the ALJs erred to the extent that they rely on certain findings of fact in HHSC's final order in *Harlingen Family Dental v. Texas Health and Human Services Commission, Office of Inspector General.* The Executive Commissioner has determined that certain of the findings in the *Harlingen Family Dental* case are incorrect and should be changed. Tex. Gov't Code § 2001.058(e)(2). Specifically, the Executive Commissioner finds that Finding of Fact No. 29 in the *Harlingen Family Dental* case is erroneous to the extent that it suggests that the Inspector General's retained expert, Dr. Charles Evans is not qualified to be an expert because he does not treat Medicaid patients (somehow lacking the requisite skills, knowledge, experience, and training). This finding is erroneous because State and federal laws require Medicaid patients to be treated to the same standard of care as patients in the general population. *See e.g.*, 25 Tex. Admin. Code § 33.71 (providing that Medicaid's orthodontia benefit is limited to cases presenting severe handicapping malocclusion); *see* 2008 TMPPM, § 1.2.5, Compliance with Federal Legislation (mandating that providers must "furnish covered Medicaid services in the same manner, to the same extent, and of the same quality as services provided to other patients").

Accordingly, the fact that Dr. Evans did not treat Medicaid patients in his practice is irrelevant to the issue of properly evaluating his qualifications (skill, knowledge, experience, and training) as an expert. To the extent that the ALJs in the instant case relied on Finding of Fact No. 29 from Harlingen in their analysis of this case and of Dr. Evans, they erred.

In addition, Finding of Fact No. 31 in the *Harlingen Family Dental* case is erroneous, and contrary to Texas law and Medicaid policy to the extent that it suggests Medicaid policy is to interpret "ectopic eruption" differently and more expansively (or more liberally) than the condition is interpreted in the general practice of dentistry. As noted above, this Finding is both factually and legally erroneous.

Harlingen Family Dental Finding of Fact No. 33 is also erroneous to the extent that it explains away evidence of fraud by impermissibly claiming Dr. Evans is not qualified (skill, knowledge, experience, and training), or that somehow his testimony lacks indicia of reliability which is contrary to legal standards defining this term) because he has not treated Medicaid patients in his private practice and because he scored the HLD indices in the *Harlingen* sample in accordance with the common interpretation in the general practice of dentistry, as opposed to the "more expansive" interpretation that the ALJ erroneously claim had been adopted by HHSC. Fact No. 33 is a misapplication of law because the *Harlingen* ALJ relied on this faulty premise.

The Executive Commissioner expressly disavows and overrules *Harlingen Family Dental* Findings of Fact Nos. 29, 31 and 33 and declares that they were wrongly decided and should be changed. Tex. Gov't Code § 2001.058(e)(2).

The Executive Commissioner also finds that the ALJs failed to both properly articulate and then properly apply the Inspector General's evidentiary burden to the evidence presented. In order to maintain the payment hold, the Inspector General is required to present prima facie evidence that is relevant, credible, and material to the issue of fraud or willful misrepresentation, or prima facie evidence that ADC has committed other, non-fraudulent program violations. *See* Tex. Hum. Res. Code § 32.0291(c); Tex. Gov't Code § 531.102(g)(2); 42 C.F.R. § 455.23; 1 Tex. Admin. Code § 371.1703(b) (2005).

The Executive Commissioner finds that when Medicaid policy and Texas laws are properly applied to the facts of record in this case the Inspector General has met his evidentiary burden to maintain a 100% payment hold. Indeed, the Executive

Commissioner finds that a 100% payment hold is required by law. Tex. Gov't Code § 531.102(g)(2); 42 C.F.R. § 455.23.

For these reasons, the Executive Commissioner declines to adopt the PFD and its proposed findings of fact and conclusions of law. Instead, the Executive Commissioner finds that the Inspector General's Exceptions have merit and should be granted.

It is now therefore ORDERED as follows:

FINDINGS OF FACT

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.DC.

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

[The Executive Commissioner rejects the ALJs' proposed FoF No. 10 because it misstates Medicaid policy, as codified in 25 Tex. Admin. Code § 33.71. (The ALJs' proposed FoF No. 10 stated: *According to the Manual, the intent of the Medicaid orthodontia program was to provide orthodontic care to clients 20 years of age or younger with severe handicapping malocclusion to improve function.*)]

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 Labia-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 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 labia-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. 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 scoresheets and PA requests substantiating the patient's condition as meeting Medicaid's requirements.

[The Executive Commissioner rejects the ALJs' proposed FoF No. 21 because the proposed finding is not relevant and rests upon an incorrect legal premise. *See State v. Durham*, 860 S.W.2d 63, 67 (Tex. 1993). (The ALJs' proposed FoF No. 21 stated: *TMHP was responsible for reviewing the filed material to evaluate whether the orthodontic services were medically necessary before granting prior authorization.*) The proposed finding ignores the responsibility ADC had to submit truthful documentation to the State (including the responsibility expressly stated in the Provider Agreement and agreed to by ADC and/or its providers), including accurate HLD scoresheets 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." ***Id.*** **]**

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. Finding of Fact No. 23 is deleted.

[The Executive Commissioner rejects Proposed FoF No. 23. (The ALJs' proposed FoF No. 23 stated: ***After ADC provided the orthodontic treatment to the patients in this case, TMHP approved payment.*****) The ALJs' proposed FoF No. 23 misstates the facts on the record and assumes facts not in evidence. Proposed FoF No. 23 erroneously assumes that ADC actually provided treatment (which was not at issue at the payment hold hearing, and no proof, therefore, has been marshaled or established as true, as would be required by the Texas Rules of Evidence, establishing that ADC ever, in fact, provided the treatment detailed in the PAs to the 63 patients in the sample). Proposed FoF No. 23 is also irrelevant (even if it were proved true), because the issue is the falsity of ADC's scoring of the HLD scoresheets, Not whether ADC actually performed treatment.]**

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. 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.

[The Executive Commissioner rejects Proposed FoF No. 26. (The ALJs' proposed FoF No. 23 stated: *ADC was unaware of the 2008 audit report and HHSC-OIG's assertion that TMHP was not properly performing prior authorization evaluations.*) The ALJs proposed finding is not relevant and rests upon an incorrect legal premise. *See State v. Durham*, 860 S.W.2d at 67. The proposed finding ignores the responsibility ADC had to submit truthful documentation to the State, including accurate HLD scoresheets 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." *Id.*]

27. In 2011, HHSC-OIG conducted a data analysis of paid Medicaid claims in Texas and 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. The HLD score sheets 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 Executive Director rejects adopt Proposed FoF No. 29. (The ALJs' proposed FoF No. 23 stated: *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 scoresheets and represented to the State the accuracy of the scores. Also, Dr. Nazari is not an orthodontist.]

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-010 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-010.

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 foranterior 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 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.

[The Executive Commissioner rejects Proposed FoF No. 39. (The ALJs' proposed FoF No. 23 stated: *The Manual's definition of ectopic eruption in the 2008 through 2011 Manual required subjective judgment to interpret.*) Proposed FoF No. 39_is erroneous because (i) the TMPPM's discussion of ectopic eruption is an instruction, not a medical definition, as discussed above; (ii) the ALJ's determination that ectopic eruption is open to subjective interpretation disregards accepted standards within the orthodontic profession. These errors reflect a misinterpretation of law and policy by the ALJs.

Proposed FoF No. 39 addresses a mixed question of fact and law, and is a so-called "legislative finding."[1] Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

40. The Manual's instruction regarding ectopic eruption was amended, effective January 1, 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

[1] A "legislative fact" is a mixed question of fact and law and defining terms is an agency function. F. Scott McCown & Monica Leo, *When Can an Agency Change the Findings of Conclusions of an ALJ?: Part Two*, 51 Baylor L. Rev. 63, 69-70 (1999).

alveolar ridge. This amendment clarified existing Texas Medicaid policy regarding conditions qualifying as ectopic eruption and did not substantively change Texas Medicaid policy.

[The Executive Commissioner rejects Proposed FoF No. 40. (The ALJs' proposed FoF No. 40 stated: *The Manual's definition of ectopic eruption was amended, effective January 1, 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 is erroneous because (i) the TMPPM's discussion of ectopic eruption is a scoring instruction, not a definition, as discussed above; and (ii) the proposed FoF misleadingly suggests that the 2012 amendment was substantive and not clarifying. The 2012 amendment to the instructions in the TMPPM clarified existing Medicaid policy. It did not effect a substantive change. R.R., Vol, 1 at 93:2-9, 94:20-23 (Dr. Altenhoff), R.R.,Vol. 3 at 193:18-194:1; 294:21-23 (Jack Stick).These errors reflect a misinterpretation of law and policy by the ALJs.

Proposed FoF No. 40 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

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

[The Executive Commissioner rejects Proposed FoF No. 41. (The ALJs' proposed FoF No. 41 stated: *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 is erroneous because (i) the TMPPM's discussion of ectopic eruption is an instruction, not a definition, as discussed above; and (ii) the proposed finding erroneously suggests that it was Texas Medicaid policy to adopt a distinct "definition" of ectopic eruption in the TMPPM that differed from ectopic eruption as generally understood within the dental profession. These errors reflect a misinterpretation of law and policy by the ALJs.

Proposed FoF No. 41 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

42. The Manuals 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.

[The Executive Commissioner rejects adopt Proposed FoF No. 42. (The ALJs' proposed FoF No. 42 stated: *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 is erroneous because (i) the TMPPM's discussion of ectopic eruption is an instruction, not a definition, as discussed above; and (ii) the proposed finding erroneously suggests that it was Texas Medicaid policy to adopt a distinct "definition" of ectopic eruption in the TMPPM that differed from ectopic eruption as generally understood within the dental profession. These errors reflect a misinterpretation of law and policy by the ALJs.

Proposed FoF No. 42 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

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

[The Executive Commissioner rejects Proposed FoF No. 44. (The ALJs' proposed FoF No. 44 stated: *After reviewing the patients' HLD score sheets, Dr. Tadlock found only one patient with ectopic eruptions that scored 26 points, Patient 15.*) Proposed FoF No. 44 is erroneous. While Dr. Tadlock <u>did</u> 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 patient 15, but <u>zero</u> points of that total were comprised of points for ectopic eruption. *See* Ex. P-77 (reflecting HLD score of 28 for Dr. Tadlock), R-49 (reflecting HLD score of 28, with 0 points for ectopic eruption).]

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.

[The Executive Commissioner rejects Proposed FoF No. 45. (The ALJs' proposed FoF No. 45 stated: *Dr. Tadlock did not apply the Manuals' definition of ectopic eruption in scoring the HLD index for the 63 ADC patients.*) Proposed FoF No. 45 is erroneous because (i) the TMPPM's discussion of ectopic eruption is an instruction, not a definition, as discussed above; (ii) the proposed finding erroneously suggests that it was Texas Medicaid policy to adopt a distinct "definition" of ectopic eruption in the TMPPM that differed from ectopic eruption as generally understood within the dental profession; and (iii) the proposed finding misconstrues Dr. Tadlock's testimony. In fact, Dr. Tadlock's testimony shows that in his view, the Manual's instructions are consistent with the generally understood definition of ectopic eruption. R.R., Vol. 1, 202:21-203:10. These errors reflect a misinterpretation of law and policy by the ALJs, as well as a 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 Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

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 were fraud or willful misrepresentations.

[The Executive Commissioner rejects Proposed FoF No. 46. (The ALJs' proposed FoF No. 46 stated: *Dr. Nazari was a credible witness and properly utilized the Manuals' definition in scoring the HLD index.*) Proposed FoF No. 46 is erroneous because (i) the TMPPM's discussion of ectopic eruption is an instruction, not a definition, as discussed above; (ii) the proposed finding erroneously suggests that it was Texas Medicaid policy to adopt a distinct "definition" of ectopic eruption in the TMPPM that differed from ectopic eruption as generally understood within the dental profession; and (iii) the proposed finding ignores evidence that directly refutes Dr. Nazari's credibility. For example, contrary to Texas Medicaid policy requirements that providers treat Medicaid patients to the same standard of care as the general population, Dr. Nazari testified that orthodontics for Medicaid patients is different than orthodontics for non-Medicaid patients. R.R., Vol. 4, 103:13-16, 104:1-4, 145:9-10. Further, Dr. Nazari was unable to define a

"severe handicapping malocclusion." *Id.*,144:17-145:6. Proposed FoF No. 46 reflects a misinterpretation of law and policy by the ALJs, as well as a mischaracterization of Dr. Nazari's credibility.

Proposed FoF No. 46 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

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 were fraud or willful misrepresentations.

[The Executive Commissioner rejects Proposed FoF No. 47. (The ALJs' proposed FoF No. 23 stated: *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 (i) the TMPPM's discussion of ectopic eruption is an instruction, not a definition, as discussed above; (ii) the proposed finding erroneously suggests that it was Texas Medicaid policy to adopt a distinct "definition" of ectopic eruption in the TMPPM that differed from ectopic eruption as generally understood within the dental profession; and (iii) the proposed finding ignores evidence that directly refutes Dr. Kanaan's credibility. For example, Dr. Kanaan testified that the word "handicapping" in the phrase "severe handicapping malocclusion" means "extreme deviation from the norm." R.R., Vol. 3, 101:3-8. Yet, 100% of the patients he treated in the statistically valid random sample exhibited severe handicapping malocclusions. *Id.*, 97:5-8. Proposed FoF No. 47 reflects a misinterpretation of law and policy by the ALJs, as well as a mischaracterization of Dr. Kanaan's credibility.

Proposed FoF No. 47 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

48. 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.

[The Executive Commissioner rejects Proposed FoF No. 48. (The ALJs' proposed FoF No. 48 stated: *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 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 their interpretation of ectopic eruption. *See e.g.* testimony of Dr. Tadlock at RR, Vol. 1, 173:3-6; 174:6-175:1; 176:14-20; 177:1-16; *see also* testimony of Dr. Nazari, RR, Vol. 4, at 144:17-145:6; and testimony of Dr. Kanaan, RR, Vol. 3, at 43-70. The totality of the evidence, which includes the testimony of ADC's own witnesses, as well as the Inspector General's experts, is much more than *prima facie*, and is relevant, credible and material. *See* Tex. Hum. Res. Code § 32.0291(c). The evidence is also reliable. The proposed finding is erroneous because implicit in it are the 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 ALJs.

Finally, this proposed FoF reflects a further misapplication of law in suggesting that the Inspector General bears the burden of proving intent to defraud Medicaid. As the ALJs acknowledge in the narrative section of their PFD, the Inspector General 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 the TMFPA. *See* PFD at 15, citing definition of "Knowingly" at section 36.0011 of the TMFPA; *see also* CoL No. 6, at page 42 of the PFD (same proposition). Nevertheless, in proposed FoF No. 48, the ALJs write that the Inspector General failed to present credible, reliable, or verifiable evidence that ADC incorrectly scored HLD indices "*to obtain Texas Medicaid benefits for patients or to obtain Texas Medicaid payments.*" The burden on the Inspector General is only to demonstrate relevant, credible and material evidence that ADC knowingly 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. To the extent that the ALJs attempt to hold the Inspector

General to the additional burden of proving intent on the part of ADC to defraud the Medicaid program, proposed FoF No. 48 is erroneous.

Proposed FoF No. 48 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. ***Montemayor*****, 2003 WL 21401591, at *8.]**

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

[The Executive Commissioner rejects Proposed FoF No. 49. (The ALJs' proposed FoF No. 49 stated: ***There is no evidence that is credible, reliable, or verifiable, or that has indicia of reliability, that ADC committed fraud or 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 the Inspector General's burden of proof in this case. As noted in CoL No. 12, to maintain the payment hold, the Inspector General 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 ALJs' determination that the Inspector General 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 TMPPM than the generally accepted definition in the orthodontic profession; (2) that said definition was open to subjective interpretation; and (3) that the 2012 changes to the TMPPM "definition" were substantive rather than clarifying, are all errors in the application of Texas Medicaid policy and law.**

Proposed FoF No. 49 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. ***Montemayor*****, 2003 WL 21401591, at *8.]**

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 misrepresentations in filing requests for prior authorization with TMHP for 61 of the 63 patients in the OIG audit sample.

[The Executive Commissioner rejects Proposed FoF No. 50. (The ALJs' proposed FoF No. 50 stated: *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. First, the proposed finding misapplies Texas law governing the Inspector General's burden of proof in this case. As noted in CoL No. 12, to maintain the payment hold, the Inspector General 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 ALJs' determination that the Inspector General 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 TMPPM than the generally accepted definition in the orthodontic profession; (2) that said definition was open to subjective interpretation; and (3) that the 2012 changes to the TMPPM "definition" were substantive rather than clarifying, are all errors in the application of Texas Medicaid policy and law.

Proposed FoF No. 50 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

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 ADC 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.

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.

[The Executive Commissioner rejects Proposed FoF No. 54. (The ALJs' proposed FoF No. 54 stated: *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 ALJs had applied the proper standard for ectopic eruption and the uncontroverted expert testimony of Dr. Tadlock to the facts of this case then 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.

Proposed FoF No. 54 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

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

[The Executive Commissioner rejects Proposed FoF No. 55. (The ALJs' proposed FoF No. 55 stated: *Patient 15, 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 ALJs use "interceptive" treatment to mean something less than comprehensive orthodontics [D8080] (and therefore outside the requirement that patients be 12 or older or have no baby teeth), the ALJs misstate the evidence. ADC billed the 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 the ALJs use "interceptive" to include code D8080, *see* Ex R-15 at § 19.18.7, they are again in error: D8080 is explicitly not applicable to patients like these who have baby teeth and are under 12 years old.

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 – D8080, or comprehensive orthodontics. The fact that ADC billed for comprehensive orthodontics when their patients did not qualify for that treatment is a program violation, and warrants a payment hold.

Specifically, with regard to Patient 15, the PFD states that ADC requested "prior authorization for interceptive treatment." PFD at 33. ADC requested

D8080, comprehensive orthodontics, for this patient, even though the patient was 9 years old and had baby teeth. Ex. P-15 at P15-0019 (ADC Prior Authorization Request Form for Patient 15 requesting "D8080".) This is a program violation. 1 Tex. Admin. Code § 371.1617(1)(K) and (5)(G).

With regard to Patient 56, ADC requested D8080 comprehensive orthodontics for this patient, even though the patient was 9 years old and had baby teeth. Ex. P-56 at P56-0015 (ADC Prior Authorization Request Form for Patient 56 requesting "D8080" for a charge of $775.00.) This is a program violation. 1 Tex. Admin. Code § 371.1617(1)(K) and (5)(G).

Finally, ADC requested D8080 comprehensive orthodontics, for Patient 60 as well, even though this patient was under 12 and had baby teeth. Ex. P-60 at P60-0004(ADC Prior Authorization Request Form for Patient 60 requesting "D8080" for a charge of $775.00.). This is a program violation. 1 Tex. Admin. Code § 371.1617(1)(K) and (5)(G).

Proposed FoF No. 55 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

56. Finding of Fact No. 56 proposed by the ALJs is deleted.

[The Executive Commissioner rejects Proposed FoF No. 56. (The ALJs' proposed FoF No. 56 stated: *Program violations range from "very innocuous" to "very important."*) Proposed FoF No. 56 misstates and misapplies testimony. Mr. Stick was asked if, generally, program violations "can fall on a continuum from the very innocuous to some that may be of greater concern, perhaps very important violations." Mr. Stick agreed to this summary. Vol. 3, 221:18-22. Mr. Stick was not commenting on the violations specific to ADC. The manner in which Proposed Fof No. 56 is written implies specific application or reference to ADC (particularly in light of Proposed CoL No. 16, which characterizes ADC's program violations as "innocuous").]

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.

[The Executive Commissioner rejects Proposed FoF No. 57. (The ALJs' proposed FoF No. 23 stated: *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 Inspector General. The 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 the ALJs misapplication of Texas Medicaid policy regarding ectopic eruption. This finding is also erroneous because it is within the sound discretion of the Executive Commissioner, and not the ALJs, to determine whether ADC's record keeping violations are cause for concern, or not.

The Inspector General based its payment hold, in part, on ADC's failure to provide records pursuant to the Inspector General's request; in some cases, ADC had these records, and entered them into evidence in this case *over a year after the Inspector General requested them.* ADC's failure to provide these records *immediately* is a program violation and may result in a payment hold. 1 Tex. Admin. Code § 371.1617(2)(A); R-14 at 1-8 ("Failure to supply the requested documents and other items, within the time frame specified, may result in a payment hold . . . or exclusion from Medicaid.").

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 he Inspector General is obligated to investigate Medicaid fraud, waste, and abuse, and, in the course of investigating, is entitled to request documents of providers. Ex R-14 (2008 TMPPM) § 1.2.3. Furthermore, the Inspector General is entitled to base payment hold determinations on the records that Medicaid providers provide in response to a proper request on the part of the Inspector General. Medicaid providers' failure to provide documents to the Inspector General 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 the Inspector General. 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.

Proposed FoF No. 57 addresses a mixed question of fact and law, and is a so-called "legislative finding." Therefore, the Executive Commissioner has complete discretion to modify it. *Montemayor*, 2003 WL 21401591, at *8.]

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. The Inspector General's burden to maintain the payment hold under section 531.102(g)(2) of the Government Code or section 32.0291(c) of the Human Resources Code, is to show by reliable or *prima facie* evidence that ADC has committed fraud or made willful misrepresentations.

   [The Executive Commissioner rejects Proposed CoL No. 4. (The ALJs' proposed CoL No. 4 stated: *HHSC-OIG had the burden of proof.*) Proposed CoL No. 4 is erroneous because it is a misstatement of the law. The Inspector General 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." Tex. Gov't Code § 531.102(g)(2) (2011). 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 or willful misrepresentation." Tex. Hum. Res. Code § 32.0291(c) (emphasis added).]

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-010 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. Texas 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. A "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 the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis." 42 C.F.R. § 455.2.

[The Executive Commissioner rejects Proposed CoL No. 10. (The ALJs' proposed CoL No. 10 stated: *"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.".*) Proposed CoL No. 10 omits words and phrases from the statute, all essential to the meaning of the statute: "'patterns identified through' provider audits;" the ALJs also deleted the phrase "and law enforcement investigations" and substituted the word "is" for "may be" and "for example" for "but not limited to." Because Proposed CoL No. 10 incorrectly states the law, the Executive Commissioner 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 not limited to" for "for example."]

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 § 32.029l(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. Hun. Res. Code § 32.029l(c) (2003).

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), 371.1617(a)(1)(A)-(C), (I), (K), (2)(A), (5)(A), (5)(G) (2005).

[The Executive Commissioner rejects Proposed CoL No. 13. (The ALJs' proposed CoL No. 13 stated: *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.

Because CoL No. 13 rests on faulty applications of law as well as erroneous interpretations of Medicaid policy the Executive Commissioner enjoys complete discretion to correct it.]

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).

[The Executive Commissioner rejects Proposed CoL No. 14. (The ALJs' proposed CoL No. 14 stated: *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 been presented of fraud or willful misrepresentation. Tex. Gov't Code § 531.102(g)(2). 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 or willful misrepresentation." Tex. Hum. Res. Code § 32.0291(c) (emphasis added).]**

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 §§ 371.1 703(b)(5),(6); 371.1617(2)(A), (5)(A) and (G) (2005).

16. ADC's failure to immediately provide HHSC-OIG with the documents and other items requested in writing is a significant program violation that, along with the extensive and overwhelming pattern of willful misrepresentations or fraud in ADC's HLD scoresheets, 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 Executive Commissioner rejects Proposed CoL No. 16. (The ALJs' proposed CoL No. 16 stated: *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 also a program violation; (2) failure to provide records to HHSC-OIG is neither a technical violation nor innocuous, as 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.

Because CoL No. 16 rests on faulty applications of law as well as erroneous interpretations of Medicaid policy the Executive Commissioner enjoys complete discretion to correct it.]

It is further ORDERED that the 100% payment hold instituted on April 4, 2012 shall remain in place until further order of the Executive Commissioner.

Signed this ___ day of _____, 201_.

_____

Kyle Janek, M.D.
Executive Commissioner