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State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

November 4, 2013

Kyle Janek
Executive Commissioner
Texas Health and Human Services Commission
4900 North Lamar Avenue, 4th Floor
Austin, Texas 78751

VIA INTERAGENCY

RE: Docket No. 529-13-0997; *Antoine Dental Center v. Texas Health and Human Services Commission, Office of Inspector General*

Dear Commissioner Janek:

Please find enclosed a Proposal for Decision in this case. It contains our recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 Tex. Admin. Code § 155.507(c), a SOAH rule which may be found at www.soah.state.tx.us.

Sincerely,

Howard S. Seitzman
Administrative Law Judge

Catherine C. Egan
Administrative Law Judge

HSS:CCE:ad
Enclosure

cc: Dan Hargrove, Attorney at Law, Walters & Kraus, LLP, 3219 McKinney Avenue, Dallas, TX 75204 – **VIA REGULAR MAIL**
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SOAH DOCKET NO. 529-13-0997

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

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

PROPOSAL FOR DECISION

Antoine Dental Center (ADC) contests the decision of the Texas Health and Human Services Commission (Commission), Office of Inspector General (HHSC-OIG) to place a 100% payment hold on all future Medicaid claims submitted by ADC. The payment hold is based primarily on HHSC-OIG's allegation that ADC engaged in fraud and willful misrepresentation in the information submitted to Medicaid for reimbursement of orthodontic services. HHSC-OIG alleged that ADC committed fraud by inflating the severity of its patients' dental conditions. HHSC-OIG also alleged that ADC committed non-fraudulent program violations by (1) failing to maintain records for the requisite period; and (2) submitting claims for reimbursement for services excluded from coverage.

This Proposal for Decision determines that the prima facie evidence failed to support a credible allegation of fraud or willful misrepresentation and failed to show that ADC filed claims for non-reimbursable services. The few non-fraudulent record retention violations that ADC committed were technical violations that do not warrant a payment hold. The Administrative Law Judges (ALJs) recommend that the payment hold be discontinued.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no disputed issues of notice or jurisdiction in this proceeding. Therefore, these matters are addressed in the Findings of Fact and Conclusions of Law without further discussion here.

The Commission filed a Request to Docket this case with the State Office of Administrative Hearings (SOAH) on November 7, 2012, and HHSC-OIG filed a Notice of Hearing on December 19, 2012. On January 15, 2013, HHSC-OIG filed the First Amended Notice of Hearing and Complaint (Notice). After conferring with the parties during the February 5, 2013 prehearing conference, the ALJ issued Order No. 2, which included a scheduling order. The deadline to file an amended Notice was April 12, 2013.

On May 25, 2013, three days before the hearing on the merits, HHSC-OIG filed a "Trial Supplement" seeking to modify two of its four allegations. HHSC-OIG represented that it filed the supplement "[t]o narrow the scope of allegations to comport with the anticipated evidence."[1] ADC moved to strike HHSC-OIG's trial supplement because it replaced or amended two of the four allegations raised by HHSC-OIG. The ALJs agreed that the trial supplement amended the complaint; therefore, HHSC-OIG's request was denied.

Prior to the commencement of the hearing on the merits, ADC requested that HSSC-OIG be bound by certain of the Commission's findings in *Harlingen Family Dentistry v. Texas Health and Human Services Commission, Office of Inspector General*, SOAH Docket No. 529-12-3180 (*Harlingen)* based upon the doctrines of res judicata and collateral estoppel. The ALJs denied ADC's motion. Having developed the evidentiary record, the ALJs find no basis for applying either doctrine in this case.

The hearing was held May 28 through 31, 2013, before ALJs Catherine C. Egan and Howard S. Seitzman in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. ADC appeared through its attorneys of record, J.A. "Tony" Canales, Hector Canales, Robert M. Anderton, Philip H. Hilder, William B. Graham, James G. Rytting, and Thomas Watkins. HHSC-OIG was represented by outside counsel Dan Hargrove, Caitlyn Silhan, James R. Moriarty, and Ketan Kharod; by Assistant Attorneys General Raymond C. Winter and Margaret M. Moore, from the Office of Attorney General of Texas; and by Enrique Varela and John R. Medlock, from HHSC-OIG. Following the receipt of the parties' briefs, the record closed on September 4, 2013.

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[1] *Trial Supplement to Respondent's Complaint* at 1 (May 23, 2013).

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

II. BACKGROUND

A. The Texas Medicaid Program for Orthodontics

The Texas Medical Assistance Program (Texas Medicaid) is implemented under Title XIX of the Federal Social Security Act and Chapter 32 of the Texas Human Resources Code. Dr. Altenhoff explained that Medicaid is designed to provide health care in Texas to the poor. However, only children from birth to 20 years of age are eligible for dental benefits.[2] For any given month, there are, on average, 2.6 million children enrolled in Medicaid in Texas.[3] Over 50% of the children in the State of Texas between the ages of birth and 18 or 19 years of age are, at any given time, on Medicaid.[4] The federal government and Texas share the cost of Medicaid, with the federal government contributing approximately 60% of the payments for Medicaid services.[5]

To increase access to Texas Medicaid dental services, in 2007 the Texas Legislature approved a 50% rate increase for dentists, but not for orthodontists.[6] Between 2007 and 2010,

[2] Tr. Vol. 1 at 44, 48.

[3] Approximately 3.4 million children have at least one day of eligibility and participation each year. Tr. Vol. 1 at 50.

[4] Tr. Vol. 1 at 50.

[5] Tr. Vol. 3 at 273; Pet. Ex. 70 at 66.

[6] Pet. Ex. 70 at 29, 72, and Attachment M-1; Tr. Vol. 3 at 264-265.

the number of children receiving dental care rose from 45% to 63%. Between 2008 and 2010, Medicaid orthodontic expenditures increased from $102 million to $185 million.[7] During this time, the number of enrolled providers also increased.[8]

The Commission is the state agency charged with the responsibility to manage the Texas Medicaid program. Deputy Commissioner Millwee testified that he was responsible for overseeing the Texas Medicaid services.[9] The Commission administers the Texas Medicaid program by contracting with healthcare providers, claims administrators, and other contractors. During the times in question in this case, Texas Medicaid Health Partnership (TMHP) was the contracted Texas Medicaid claims administrator.[10] Until recently, Texas Medicaid paid for orthodontic services on a fee-for-service basis, and the fee paid for orthodontic service remained unchanged during that period.[11]

In March of 2012, Texas Medicaid dental benefits were transferred to a managed care system, with three dental maintenance organizations (DMOs)[12] primarily responsible for dental benefits, including orthodontia and prior authorizations.[13] During all applicable periods, HHSC-OIG was responsible for monitoring and investigating any allegations of fraud, waste, and abuse associated with Texas Medicaid.[14]

In 2008 through 2011, if a provider wanted to become a Texas Medicaid Dental Provider, the provider had to complete the Medicaid "Dental Provider Enrollment Application." If the provider satisfied the eligibility requirements, the provider was allowed to provide dental

[7] Pet. Ex. 70, Attachment M-1.

[8] Tr. Vol. 3 at 262.

[9] Pet. Ex. 70 at 6-7. Mr. Milwee's deposition was taken on April 4, 2012, in *Harlingen* and was admitted into evidence in this case as Pet. Ex. 70.

[10] The Commission contracted with ACS Healthcare, now owned by Xerox, as the prime contractor responsible for reviewing, processing, and paying claims on behalf of the Texas Medicaid program. TMHP is a partnership of several different corporations, including ACS Healthcare, and acts as the third-party administrator for the State of Texas. Tr. Vol. 3 at 196, 237-238; Pet. Ex. 70 at 16.

[11] Tr. Vol. 3 at 264-265.

[12] In December 2012, one DMO withdrew from the program. Tr. Vol. 3 at 264.

[13] Tr. Vol. 3 at 264.

[14] Tr. Vol. 3 at 188-189.

services to Medicaid patients. 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.[15] A provider also agreed that all information submitted with claims would be true, complete, and accurate, and would be verifiable "by reference to source documentation maintained by Provider in accordance with the Manual."[16] Dr. Altenhoff explained that the Manual,

> gives providers an overall guidance as to not only what their responsibilities are to become a provider, but also in treating of patients, how to submit claims, how to submit prior authorizations, what services are benefits of the program, what limitations there are, whether those limitations are age or could be also who was qualifying for it, for the services that are being provided.[17]

The orthodontic program, she clarified, only corrects severe handicapping malocclusions, a touching of teeth that is so inaccurate that it prevents the child from being able to chew or bite normally.[18] Orthodontic services provided solely for cosmetic reasons were not covered.[19] In general, orthodontic benefits were further limited to the treatment of children 12 years of age or older with a severe handicapping malocclusion.[20]

To be reimbursed for orthodontic care, a dental provider had to obtain prior authorization from TMHP, which was responsible for reviewing the filed material to evaluate whether orthodontic services were medically necessary.[21] Mr. Millwee explained that prior authorization was a process used "to review clinical information to arrive at a decision about whether or not to

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[15] According to the Dental Provider Enrollment Application completed by ADC, in consideration of Medicaid payments a provider agreed "[t]o become familiar with the provisions and procedures contained in the *Texas Medicaid Provider Procedures Manual* ('the Manual') and the bimonthly updates to the Manual published in the *Texas Medicaid Bulletin* that govern the delivery of and payment for authorized medical or dental services to eligible Medicaid recipients." Res. Ex. 1 at 4.

[16] Res. Ex. 1 at 4.

[17] Tr. Vol. 1 at 52.

[18] Tr. Vol. 1 at 58-59.

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

[20] In addition to meeting the 26-point threshold, the child had to have a dysfunctional bite. Tr. Vol. 1 at 60. The age requirement was not added until 2009. *See* Res. Ex. 15 at 19-38 ¶ 19.19.1 (2009 Manual).

[21] A copy of the blank score sheet is attached to this Proposal for Decision as Appendix 1.

authorize services for that particular client."[22] Prior authorization was a condition for reimbursement of orthodontic services, but did not guarantee payment.[23] The provider was still required to show that the orthodontic procedure was medically necessary under the terms and conditions of the Manual. To obtain prior authorization, the provider had to submit to TMHP a Handicapping Labio-lingual Deviation (HLD) Index score sheet together with supporting dental records, such as photographs and radiographs. Providers were required to submit true, complete, and accurate information to support a request for prior authorization and were also required to maintain patient records for five years.[24]

The HLD Index is an index measuring the existence or absence of handicapping malocclusion[25] and its severity.[26] It is a tool to measure whether a patient qualifies for the public funding program, but it neither makes a diagnosis nor prescribes a treatment. It should be noted that the American Association of Orthodontists has not found any index, including the HLD, to be scientifically valid.[27] The HLD score sheet assigns a certain number of points for nine observed conditions: cleft palate,[28] severe traumatic deviations,[29] overjet,[30] overbite,[31] mandibular protrusion,[32] open bite,[33] ectopic eruption,[34] anterior crowding,[35] and labio-lingual

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[22] Pet. Ex. 70 at 12.

[23] Res. Ex. 14 at 19-37 ¶19.18.2 (2008 Manual).

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

[25] Occlusion is how opposing teeth meet, or fit together, when the mouth is closed. Tr. Vol. 1 at 58.

[26] Tr. Vol. 3 at 99-100.

[27] Tr. Vol. 1 at 222-223.

[28] With a cleft palate, the mouth does not come together and join completely. A cleft palate automatically qualifies for orthodontics. Tr. Vol. 1 at 63.

[29] A head injury involving facial accidents. Res. Ex. 14 at 19-36 ¶19.18.1, 19-42 ¶19.20 (2008 Manual).

[30] Overjet is the linear measurement between the surface of the front tooth to the bottom teeth and indicates how much the upper teeth stick out. Tr. Vol. 1 at 65; Tr. Vol. 3 at 104.

[31] Overbite is the vertical overlap between the upper central incisors (two upper front teeth) and the lower central incisors (two lower front teeth). A normal overbite is approximately three millimeters, measured from the edges of the teeth. In an extreme overbite, the lower teeth can bite into the roof of the mouth. Tr. Vol. 1 at 65.

[32] Mandibular protrusion is when the lower jaw (mandible) protrudes beyond the upper jaw (maxilla) causing the lower front teeth to be in front of the upper front teeth. Tr. Vol. 1 at 66.

[33] Open bite occurs when the edges of the front teeth do not touch. When the mouth is closed, there is a visible gap between the edge of the upper front teeth and the edge of the lower front teeth. Tr. Vol. 1 at 66.

[34] Ectopic eruption will be discussed at length below.

spread.[36] Correction of severe handicapping malocclusion with full banding (braces) generally required a minimum score of 26 points on the HLD Index.[37] If the HLD Index did not meet the 26-point threshold, a provider could also submit a narrative to establish the medical necessity of the treatment.[38]

The Manual instructed dental providers on how to score their patients on the HLD score sheet. The Manual further instructed providers to be conservative in scoring.[39] Of particular relevance to this case are the following instructions in the 2008-2011 Manuals on how to score the HLD Index:

> **Ectopic Eruption**. An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge.[40] Do not include (score) teeth from an arch if that arch is to be counted in the following category of Anterior Crowding. For each arch, either the ectopic eruption or anterior crowding may be scored, but not both.[41]
>
> **Anterior Crowding.** Anterior teeth that require extractions as a prerequisite to gain adequate room to treat the case. If the arch expansion is to be implemented as an alternative to extraction, provide an estimated number of appointments required to attain adequate stabilization. Arch length insufficiency must exceed 3.5 mm to score for crowding on any arch. Mild rotations that may react favorably to stripping or moderate expansion procedures are not to be scored as crowded.[42]

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[35] Anterior crowding requires 3.5 millimeters of crowding and scores a maximum of 10 points, five for the upper arch and five for the lower arch. Tr. Vol. 1 at 211-212.

[36] The labio-lingual spread is the space (gap) between the front teeth. Tr. Vol. 1 at 67-68.

[37] Res. Ex. 14 at 19-36 ¶19.18 (2008 Manual).

[38] Tr. Vol. 1 at 72-73.

[39] Res. Ex. 14 at 19-43 ¶19.20 (2008 Manual).

[40] The alveolar ridge is "the bony ridge or raised thickened border on each side of the upper or lower jaw that contains the sockets of the teeth . . . ." Merriam-Webster's Medical Dictionary 22 (1995).

[41] Res. Ex. 14 at 19-43 ¶19.20 (2008 Manual).

[42] Res. Ex. 14 at 19-43 ¶19.20 (2008 Manual). According to the Manual, the provider was not to double-score ectopic eruption and anterior crowding. The provider was to score "the more serious condition." Res. Ex. R-14 at 19-43 ¶19.20.1 (2008 Manual).

B. ADC's Practice

Dr. Nazari has owned ADC since 1998. ADC operates two dental clinics in Houston, Texas, that treat Medicaid and private pay clients. In 2010, approximately 60% to 70% of ADC's patients were Medicaid patients.[43] Although Dr. Nazari is not an orthodontist, he has taken over 750 education hours pertaining to orthodontics and occlusions and another 700 hours in "cosmetic restorative, implant."[44] In 2006, ADC hired Dr. Kanaan, an orthodontist, who completed dental school at Aleppo University in 2000 and his residency at St. Louis University in 2005. He then did a one-year fellowship with the cleft lip and palate team at St. Louis Children's Hospital.[45]

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.[46]

C. The 2008 HHSC-OIG Audit of TMHP[47]

On August 29, 2008, HHSC-OIG issued a performance audit report regarding TMHP's prior authorization process between September 1, 2006, and March 31, 2008 (the 2008 audit report). For some time, HHSC-OIG believed that there were ongoing problems with the orthodontic program because of the substantial rise in program expenditures.[48] The purpose of the 2008 audit was to determine if TMHP's prior authorization process complied with the Texas Administrative Code, the applicable federal regulations, and its contractual obligations to the Commission.[49]

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[43] Tr. Vol. 3 at 8; Vol. 4 at 33.

[44] Tr. Vol. 4 at 90.

[45] Tr. Vol. 3 at 97-98; Vol. 4 at 92.

[46] ADC's Medicaid provider application and enrollment agreement is at Res. Ex. 1.

[47] A copy of the 2008 audit report is attached to Pet. Ex. 70 at Attachment 5, behind Tab 6.

[48] Tr. Vol. 3 at 195-197.

[49] Pet. Ex. 70 Attachment 5, behind Tab 6.

According to the 2008 audit report, the prior authorization function was "a utilization management measure allowing payment for only those services that are medically necessary, appropriate, and cost-effective, and reducing the misuse of specified services."[50] HHSC-OIG reported that TMHP's prior authorization team failed to review the support documentation submitted by providers with the HLD score sheet as required.[51] HHSC-OIG also determined that TMHP's staff did not have the dental credentials necessary to evaluate whether the additional documentation supported the HLD score. TMHP's staff only referred about 10% of the orthodontic prior authorization requests to the TMHP dental director for review.[52] Because of its findings, HHSC-OIG recommended that TMHP increase its training for its preauthorization staff. According to Mr. Milwee, TMHP took no corrective action until September 2011, when it terminated its dental director.[53]

D. HHSC-OIG's Investigation of ADC

In June 2011, HHSC-OIG began a data analysis of paid Medicaid claims in Texas that was subsequently fueled by stories aired by WFAA, a Dallas television station, in the fall of 2011.[54] HHSC-OIG examined providers with the greatest number of prior authorizations and determined that those providers were receiving a large percentage of the Medicaid orthodontic benefits.[55] ADC ranked in the top 25 providers. HHSC-OIG initiated fraud investigations against many of these providers, including ADC. Of the approximately 6,500 cases for which ADC received prior authorization in 2009, 2010, and 2011, using a method of statistical sampling, HHSC-OIG selected 63 cases to audit.[56] HHSC-OIG presented no expert testimony with regard to the validity of the statistical sampling methodology. Neither the sampling

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[50] Pet. Ex. 70 Attachment 5, behind Tab 6 at P-01451.

[51] Tr. Vol. 3 at 196.

[52] Pet. Ex. 70 Attachment 5, behind Tab 6 at P-01452.

[53] Pet. Ex. 70 at 74-75.

[54] Pet. Ex. 70 at 24 and 26; Tr. Vol. 3 at 195-198.

[55] Tr. Vol. 3 at 197.

[56] Tr. Vol. 3 at 199-208; Pet. Ex. 82A.

methodology nor the audit included cases for which ADC examined a patient, but for which ADC did not file a request for prior authorization.[57]

After identifying and obtaining the files to be audited, HHSC-OIG sent the physical files to a consulting orthodontist, Dr. Evans, for review and identification of program errors or other problems.[58] HHSC-OIG represented that it also sent field investigators to interview ADC's office staff, dentists providing the services, and patients and their parents/guardians.[59]

According to HHSC-OIG, for the 63 ADC patients Dr. Evans reviewed, he concluded that all of the HLD scores were inflated.[60] Based upon the "100 percent error rate" for the 63 audited cases, HHSC-OIG determined fraud was involved.[61] As a result, HHSC-OIG sent ADC a letter on April 4, 2012, imposing a payment hold on all future claims submitted by ADC to Texas Medicaid, as permitted under 1 Texas Administrative Code § 371.1703 and 42 C.F.R. § 455.23.[62] According to the letter, the reason for the payment hold was that HHSC-OIG had received "a credible complaint alleging fraud" against ADC for claims it submitted from November 1, 2008 through August 31, 2011.[63] ADC timely requested a hearing concerning the payment hold, and the matter was referred to SOAH. During this period, HHSC-OIG also referred ADC to the Medicaid Fraud Control Unit of the Office of the Attorney General (MFCU), and on March 29, 2012, MFCU opened an investigation based on HHSC-OIG's allegations of fraud, misrepresentation, and Medicaid program violations.

In May 2012, after the payment hold was imposed, HHSC-OIG retained another orthodontist, Dr. Tadlock, to review ADC's clinical records. Dr. Tadlock found that ADC's

[57] Thus, there is no indication in the record as to how many patients ADC scored who fell below the 26-point threshold and for whom prior authorizations were not requested.

[58] Tr. Vol. 3 at 209.

[59] Tr. Vol. 3 at 209-211.

[60] Tr. Vol. 3 at 231.

[61] Tr. Vol. 3 at 231-232.

[62] All references are to the 2005 Texas Administrative Code, unless specifically otherwise noted.

[63] Pet. Ex. 82-A. In closing arguments, HHSC-OIG represented that at the time of the hearing it had retained $555,779.41, 6.68% of ADC's total billings.

clinical records for 62 out of 63 Medicaid patients did not support ADC's HLD score. In all 63 cases, the only scoring component he evaluated was ADC's scoring for ectopic eruptions.

E. HHSC-OIG's Allegations

HHSC-OIG maintains that it was entitled to impose a 100% payment hold against ADC because, as to the period November 1, 2008, through August 31, 2011: (1) ADC failed to maintain required records and other documents; (2) ADC made false statements to meet prior authorization requirements; (3) ADC received payments for services and items that were not reimbursable; and (4) HHSC-OIG had credible allegations of fraud supporting the payment hold.

HHSC-OIG also pleaded that ADC committed various non-fraudulent program violations. Without specifically identifying patients, HHSC-OIG charged that ADC failed to maintain dental models, HLD score sheets, and treatment notes for dates of services, and failed to provide letters to TMHP for potential extenuating conditions that warranted treatment. By the time of the hearing, HHSC-OIG reduced its "numerous" incidences to the following: (1) six, not 70, dental models; (2) five, not 60, HLD score sheets; (3) three, not 12, dates of service without corresponding treatment notes.

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

III. APPLICABLE LAW

A. Authority to Impose Payment Holds

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

Texas Government Code § 531.102(g)(2), effective September 1, 2011, mandates that HHSC-OIG impose a hold on payment of claims for reimbursement submitted by a provider on receipt of reliable evidence that the circumstances giving rise to the payment hold involve fraud or willful misrepresentation under the state Medicaid program. This statute references the United States' Department of Health and Human Services' regulation at 42 C.F.R. § 455.23. The federal rule mandates a suspension of all Medicaid payments to a provider after the state Medicaid agency, in this case HHSC-OIG, determines that there is a credible allegation of fraud for which an investigation is pending, unless the agency has good cause not to suspend payments or to suspend payments only in part.[64]

The federal regulation further provides that, if the state's MFCU accepts a referral for investigation of the provider, the payment suspension may be continued until the investigation and any associated enforcement proceedings are completed. The state must request quarterly a certification from the MFCU that the matter continues to be under investigation, "thus warranting continuation of the suspension."[65]

Texas Human Resources Code § 32.0291(b), in effect since 2003, states that, notwithstanding any other law, the Commission may impose a hold on payment of future claims submitted by a provider if there is reliable evidence that the provider has committed fraud or willful misrepresentation regarding a claim for reimbursement under the medical assistance program.[66] Section 32.0291(c) provides that, in a SOAH hearing on a payment hold, the Commission "shall discontinue the hold unless the department makes a prima facie showing at the hearing that the evidence relied on by the department in imposing the hold is relevant, credible, and material to the issue of fraud or willful misrepresentation."

The Commission rules authorize the imposition of a payment hold against a provider, prior to the completion of an investigation, based on "prima facie" evidence of fraud or willful

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[64] The payment suspension is to last until the agency determines there is insufficient evidence of fraud, or legal proceedings related to the alleged fraud are completed. 42 C.F.R. § 455.23(c) (2011).

[65] 42 C.F.R. § 455.23(d)(3)(ii) (2011).

[66] The statute refers to the "department," which is defined as the Commission or an agency operating part of the medical assistance program. Tex. Hum. Res. Code § 32.003(3) (1995).

misrepresentation or of various other violations, including violations not rising to the level of fraud, such as submitting claims for services that are not reimbursable or failing to comply with the terms of the Medicaid program provider agreement.[67]

B. Burden of Proof

HHSC-OIG acknowledged that it has the burden to present reliable evidence that ADC engaged in fraud or made willful misrepresentations to secure Medicaid payment that ADC knew or should have known were false.[68] HHSC-OIG also has the burden to present "prima facie evidence" of the existence of non-fraudulent program violations.[69]

As noted above, Section 531.102(g)(2) of the Texas Government Code states that HHSC-OIG may only 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, as applicable." Section 455.23 deals with the suspension of payment in cases of fraud. The pertinent portions of this federal regulation state:

> **(a) Basis for suspension. (1)** The State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.
> **(2)** The State Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments.
> **(3)** A provider may request, and must be granted, administrative review where State law so requires.

The federal regulations define "credible allegation of fraud" as:

> . . . an allegation, which has been verified by the State, from any source, including but not limited to the following:

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[67] 1 Tex. Admin. Code §§ 371.1703(b)(3),(5) and (6); 371.1617(1)(A)-(C), (I), (K), (2)(A), (5)(A) and (G) (2005). The state rules expressly cite to Title 42 of the Code of Federal Regulations as a governing authority. 1 Tex. Admin. Code § 371.1605 (2005).

[68] HHSC-OIG's Post-Hearing Brief at 23-24. *See* Tex. Hum. Res. Code § 32.0291(b) (2003) and 1 Tex. Admin. Code §§ 371.1613, 371.1617, and 371.1703 (2005).

[69] 1 Tex. Admin. Code § 371.1703(b)(5) (2005).

(1) Fraud hotline complaints.

(2) Claims data mining.

(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency **has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.**[70]

The term "fraud" is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."[71]

The applicable statutes and rules place the burden on HHSC-OIG to provide prima facie evidence of non-fraudulent program violations supporting a payment hold.[72] To establish a fraudulent program violation, HHSC-OIG must provide credible, verifiable evidence with indicia of reliability.[73] Although the burden is less than a preponderance of the evidence, the statutes and rules clearly require that the evidence supporting the payment hold be credible, verifiable, and have indicia of reliability. Moreover, the federal regulation requires the agency to review carefully all allegations, facts, and evidence before imposing the payment hold.

C. Percentage Withheld

If HHSC-OIG proves that it had a prima facie case to impose a payment hold, then the issue becomes what percentage of future Medicaid payments should be withheld from ADC. Under the federal regulations, if HHSC-OIG establishes that a credible allegation of fraud is being investigated, then the "agency must suspend all Medicaid payments . . . ."[74] However, the rule allows the agency to deviate from imposing a 100% payment hold to impose either no

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[70] 42 C.F.R. § 455.2 (2011) (emphasis added).

[71] 42 C.F.R. § 455.2 (2011).

[72] Tex. Gov't Code § 531.102(g)(2) (2011); Tex. Hum. Res. Code § 32.0291 (2003).

[73] The parties used phrase "prima facie evidence" in addressing both fraud claims and non-fraudulent program violations.

payment hold or a partial payment hold upon a showing of good cause. The state rules also allow an ALJ or judge of any court of competent jurisdiction to order HHSC-OIG to lift the payment hold in whole or in part.[75]

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

1. Fraud and Willful Misrepresentation

According to the federal regulations, fraud includes an "intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself or some other person." It includes any act that constitutes fraud under applicable federal or state law.[76] The elements of fraud are determined by state law.

Chapter 36 of the Texas Human Resources Code specifically governs Medicaid fraud prevention. Section 36.002(1) states that it is an unlawful act to knowingly make or cause to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized. "Knowingly" requires the person have knowledge of the information, to act with conscious indifference to the truth or falsity of the information, or to act in reckless disregard of the truth or falsity of the information. Proof of the person's specific intent to commit an unlawful act under § 36.002 is not required to show that a person acted "knowingly."[77] Texas Government Code § 531.1011(1) parrots the federal regulations in defining "fraud" as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person, including any act that constitutes fraud under applicable federal or state law.

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[74] 42 C.F.R. § 455.23(a)(1) (2011).

[75] 1 Tex. Admin. Code § 371.1709(e)(3)(I) (2012).

[76] 42 C.F.R. § 455.2 (2011).

[77] Tex. Hum. Res. Code § 36.0011(b) (2005).

2. Non-Fraudulent Program Violations

According to 1 Texas Administrative Code § 371.1617, HHSC-OIG is authorized to impose a payment hold for program violations.[78] This includes a provider's failure to maintain patients' records and documentation for the time required by the provider's licensing agency, in this case the Texas Board of Dental Examiners (TBDE), or the Manual.

IV. ECTOPIC ERUPTION

HHSC-OIG's fraud allegation turns primarily upon whether the Manual defines ectopic eruption for Texas Medicaid HLD scoring purposes. If it does, then the issue is whether ADC scored its HLD Index in accordance with the Manual's definition. If the Manual does not define ectopic eruption, the issue then becomes whether there is an accepted professional understanding of ectopic eruption that ADC failed to use when scoring the HLD score sheets. For the reasons discussed below, the ALJs find that the Manual defines ectopic eruption for purposes of scoring the Texas Medicaid Index.

HHSC-OIG's allegations of fraud against ADC largely rest on its experts' view that ADC's providers were too liberal in their scoring of ectopic eruptions. As discussed above, the Manual described the categories of the HLD Index and instructed providers on how to score these categories. During this time, the provision regarding ectopic eruptions stated:

> **Ectopic Eruption**
>
> An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge. Do not include (score) teeth from an arch if that arch is to be counted in the following category of Anterior Crowding. For each arch, either the ectopic eruption or anterior crowding may be scored, but not both.[79]

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[78] *See also,* 1 Tex. Admin. Code § 371.1709 (2012).

[79] Res. Ex. 14 at 19-42 ¶19.20 (2008 Manual).

The Manual amended the category ectopic eruption, effective January 1, 2012, 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.[80]

Drs. Altenhoff and Tadlock opined that the language in the Manual for ectopic eruption is not a definition and maintained that ectopic eruption is defined by the professional literature and practice. Their testimony, especially Dr. Tadlock's, addressed Finding of Fact No. 34 in *Harlingen* that there was no evidence in that record of "a widespread, non-Medicaid understanding of the specifics of the meaning of ectopic eruption among orthodontic providers."

Dr. Tadlock relied upon a well-recognized textbook[81] by William R. Proffit, D.D.S., for the definition of "ectopic eruption."[82] According to Dr. Tadlock, Dr. Proffit defines an ectopic eruption as a tooth being in the wrong place.[83] Alternatively, Dr. Tadlock agreed it could be described as a tooth in an abnormal position, but he took issue with the contention that abnormal position is different from being in the wrong place.[84] Dr. Tadlock acknowledged that Texas Medicaid is free to define ectopic eruption.[85] Dr. Tadlock also acknowledged that the issue is whether the Texas Medicaid definition is more expansive than the definition he used in his scoring.[86] Dr. Altenhoff testified the Manual controls,[87] and therefore, any definition in the Manual takes precedence over any other definition, including any definition that may exist in professional literature.

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[80] Pet. Ex. 78 at 8.

[81] *Contemporary Orthodontics*, 3rd ed.

[82] Tr. Vol. 1 at 143.

[83] Tr. Vol. 1 at 143-144, 191.

[84] Tr. Vol. 1 at 191-192.

[85] Tr. Vol. 1 at 189.

[86] Tr. Vol. 1 at 232.

[87] Tr. Vol. 1 at 103.

ADC argued that the Manual defines ectopic eruption and controls the scoring of the Texas Medicaid HLD Index. Dr. Kanaan, like Dr. Tadlock, is an orthodontist. Dr. Kanaan took issue with Dr. Tadlock's statement that Dr. Proffit had defined the term "ectopic eruption." Dr. Kanaan asserted that Dr. Proffit describes, but provides no clear definition of, ectopic eruption.[88] He believes the language in the Manual provides a definition of ectopic eruption for use in scoring a Medicaid patient and provides two non-exclusive examples and scoring instructions. Dr. Kanaan identified several reasons Dr. Proffit's description of ectopic eruption does not apply to scoring the HLD index. These included:

- The Medicaid program covers children 12 or older, while Dr. Proffit's description of ectopic eruption deals with mixed dentition. Mixed dentition primarily involves children ages 6 and 7 when the upper molars are coming down and may be blocked by baby teeth.[89]

- Because Dr. Proffit is concerned with mixed dentition, he focused on the posterior teeth. The Manual excludes posterior teeth and allows consideration of only anterior teeth.[90]

- The two non-exclusive examples of ectopic eruption found in the Manual, high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge, are defined by Dr. Proffit not as ectopic eruption, but as "abnormal eruption."[91] Thus, the Manual combines the two concepts, ectopic eruption and abnormal eruption.[92]

- The Manual requires the Medicaid provider to use either ectopic eruption or anterior crowding, but not both.[93] Dr. Proffit has no such prohibition.[94]

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[88] Tr. Vol. 3 at 11, 113.

[89] Tr. Vol. 3 at 113-115.

[90] Tr. Vol. 3 at 114.

[91] Tr. Vol. 3 at 115-116.

[92] Tr. Vol. 3 at 115.

[93] Ectopic eruption is a description of the location of a tooth while anterior crowding is a quantitative measurement of the lack of space. Tr. Vol. 3 at 123.

[94] Tr. Vol. 3 at 116.

Dr. Kanaan stressed that there are other differences between the Manual and the general practice of orthodontics:

- Ectopic eruption in the orthodontic community includes molars, but the Manual expressly excludes posterior teeth.[95]
- There are differences in how one measures the various conditions, such as open bite.[96]
- William S. Parker, D.D.S., author of "The HLD (CalMod) Index and Index Question," acknowledges confusion surrounding the definition of ectopic eruption. While Dr. Parker considers teeth more than 50% blocked ectopic, Dr. Proffit does not consider them ectopic.[97]
- The Manual uses one scoring mandate for anterior crowding while general orthodontic practice uses another scoring mandate.[98]
- While Dr. Proffit considers leaning or slanted teeth to be ectopic,[99] the January 1, 2012 amendment to the Manual expressly eliminated rotated or slanted teeth from ectopic eruption.[100]

The evidence established that there are significant differences between the language of the Manual and the general practices in the orthodontic community. There are even differences within the orthodontic community itself on the meaning and interpretation of various terms, including ectopic eruption.[101] However, as mentioned previously, even if there were a uniform non-Medicaid understanding of ectopic eruption, it is relevant only if the Manual's language does not define the term.

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[95] Tr. Vol. 1 at 189, 195; Tr. Vol. 3 at 114.

[96] Res. Ex. 37 at 296, 303; Tr. Vol. 3 at 107.

[97] Tr. Vol. 3 at 118-119.

[98] For example, for 4 millimeters of crowding, four points would be scored in general orthodontic practice while five points would be scored according to the Manual. Tr. Vol. 1 at 211-212.

[99] Tr. Vol. 3 at 134-138.

[100] Tr. Vol. 3 at 133-134; Pet. Ex. 81 at 53.

[101] For example, Harry L. Draker, D.D.S., wrote "from a review of the literature, moreover, it would appear that all orthodontists themselves do not necessarily agree on a definition of malocclusion." Res. Ex. 37 at 296. Additionally, a required reading for the American Board of Orthodontics examination, "The Six Keys to Normal Occlusion" written by Lawrence F. Andrews, D.D.S., defines normal as straight with no rotation and no spacing. Dr. Tadlock did not agree with this definition of "normal." Tr. Vol. 3 at 126-127, Pet. Ex. 83.

HHSC-OIG asserted that the language in the Manual is only a definition if the Manual expressly states it is a definition. The ALJs disagree with such a limited reading of the Manual. A definition is "[a] description of a thing by its properties; an explanation of the meaning of a word or term . . . . The process of stating the exact meaning of a word by means of other words."[102]

The Manual states that ectopic eruption is "[a]n unusual pattern of eruption." Using the phrase "such as," the Manual describes an unusual pattern of eruption with two non-exclusive examples: (1) high labial cuspids; or (2) teeth that are grossly out of the long axis of the alveolar ridge. The Manual continues by giving a scoring instruction for the HLD Score Sheet—"Do not include (score) teeth from an arch if that arch is to be counted in the following category of Anterior Crowding. For each arch, either the ectopic eruption or anterior crowding may be scored, but not both."

Even though the Manual does not use the word "definition," a cursory examination of the other categories listed in this section of the Manual shows a significant difference between them and ectopic eruption. The terms overjet, overbite, mandibular protrusion, open bite, and labio-lingual spread all begin with the word "Score."[103] There is no attempt to describe or define the terms.[104] But, the Manual does describe, with some degree of specificity, ectopic eruption. Although it does not expressly use the word definition, the Manual defines the term by a description of its properties.

The ALJs find that the plain language in the Manual defines an ectopic eruption as "[a]n unusual pattern of eruption." "[T]eeth that are grossly out of the long axis of the alveolar ridge" are but one example of an unusual pattern of eruption. By failing to further define or restrict its example,[105] the Manual leaves interpretation of those words to professional judgment. Because

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[102] Black's Law Dictionary 510 (Rev. 4th Ed. 1968).

[103] Res. Ex. 14 at 19-42 and 19-43 ¶19.20 (2008 Manual).

[104] Arguably, the Manual may define the terms "severe traumatic deviations" and "anterior crowding" by providing descriptive limits; however, those terms are not in dispute in this case.

[105] As previously noted, in 2012 the Commission did restrict the definition of ectopic eruption by excluding teeth that are rotated or teeth that are leaning or slanted.

judgment is involved, there will be professional differences of opinion and subjective determinations.

V. FRAUD OR WILLFUL MISREPRESENTATIONS

ADC argued that because it properly complied with the prior authorization process, HHSC-OIG is now barred from imposing a payment hold based on allegations that ADC artificially inflated its HLD scores. It also complained that the only reason HHSC-OIG conducted the investigation and imposed the payment hold on ADC was as a response to a series of critical news stories regarding Texas Medicaid orthodontic expenditures.[106]

The reason HHSC-OIG initiated its investigation is irrelevant so long as the investigation was properly performed and reliable credible evidence supports the payment hold. HHSC-OIG may audit any Medicaid provider to assure that the provider has complied with the program requirements. Therefore, the ALJs find this argument has little, if any, merit.

ADC also argued that the prior authorization process precludes HHSC-OIG from now claiming that ADC artificially inflated the HLD score sheet.[107] The prior authorization process was designed to assure the requested services were Medicaid-eligible. It does not protect a provider from legal liability for fraud and willful misrepresentation.

A. Payment Hold Based on Fraud or Willful Misrepresentation

HHSC-OIG argued that when it imposed the payment hold, its investigation verified credible allegations of fraud against ADC. Emphasizing that it only had to provide evidence with "indicia of reliability" sufficient to support a "reasonable suspicion," HHSC-OIG maintained that it met its burden. According to Mr. Stick, HHSC-OIG Deputy Inspector General, HHSC-OIG relied on statistical data, field investigations, and Dr. Evans' findings to support a credible allegation of fraud. The evidence admitted into this record does not include

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[106] The WFAA, Dallas television station, news stories were aired in the fall of 2011. Shortly after these news reports, the federal Office of Inspector General began auditing the Commission to determine if it, through its contractor TMHP, properly managed the prior authorization process. Pet. Ex. 70 at 64-65, and Attachment M-8, behind Tab 9.

[107] ADC's Closing Argument at 2.

any statements or reports from the field investigators, ADC's clients, or the clients' parents/guardians. Although Dr. Evans did not testify, his report is in evidence. The underlying statistical data and algorithms are not in evidence. The evidence supporting HHSC-OIG's initial determination to impose a payment hold for fraud is limited to its conclusions from the statistical data and Dr. Evan's report. HHSC-OIG subsequently offered evidence in support of its payment hold for fraud based upon Dr. Tadlock's findings. In their analysis of the evidence for imposing a payment hold for fraud, the ALJs will address both the statistical data and the experts' testimony regarding the patients at issue.

1. Statistical Data

Mr. Stick testified that the year before the payment hold, November 2010 to November 2011, ADC submitted prior authorization requests for approximately 106 patients per month, or approximately 1,272 Texas Medicaid patients for the year.[108] He contrasted that with the period November 2011 through March 2012, when ADC submitted and received prior authorizations for only 10 Medicaid patients per month.[109] Mr. Stick noted that ADC had not received any new prior authorizations after March 2012, but he agreed that he did not know whether ADC had submitted any prior authorization requests.[110] Mr. Stick concluded from this data that until HHSC-OIG began its November 2011investigation, ADC had been inflating its HLD scoring.

Dr. Nazari disputed the validity of this reasoning. He testified that the decline in the number of Medicaid patients that ADC saw after November 2011 was caused by several factors. He explained that December is always ADC's slow month because of the holidays. Not many patients seek dental treatment over the holidays, and ADC is closed part of the time.[111] Dr. Nazari noted that ADC did not file any claims in January and February 2012, because providers were notified in a Texas Medicaid bulletin that prior authorization requests for most orthodontic services were suspended from January 1, 2012, through February 29, 2012.[112]

[108] Tr. Vol. 3 at 266-267.

[109] Tr. Vol. 3 at 266-267.

[110] Tr. Vol.3 at 267-268.

[111] Tr. Vol. 4 at 28.

[112] Tr. Vol. 4 at 82; Pet. Ex. 78.01 at 1.

Between March and April 4, 2012, Dr. Nazari said that ADC was dealing with the chaos created by the switch to managed dental care because each organization (MCNA, Dental Quest, and Delta Dental) had its own specific standards. He added that it was unclear which organization and provider would be responsible for Medicaid patients already undergoing orthodontic treatment.[113] He said ADC "could not take the responsibility to bring any more patients on board and not being [sic] able to treat them."[114]

2. Relevant Experts' Opinions Regarding Patients

a. Dr. Evans

At the time HHSC-OIG decided to impose a 100% payment hold (April 4, 2012), only Dr. Evans had reviewed the HLD score sheets for HHSC-OIG. Of the 63 patient records reviewed by Dr. Evans, he did not find one patient that qualified for Medicaid benefits. Based in large part on Dr. Evans' opinion that ADC inflated the HLD scores, HHSC-OIG imposed a payment hold on ADC's future Medicaid payments. The ALJs are unable to assess the credibility and reliability of Dr. Evans' opinions because he did not testify in this proceeding. More importantly, the definition of ectopic eruption that he used for scoring the HLD Index is uncertain. The ALJs note, however, in *Harlingen,* the Commission made several findings regarding Dr. Evans' qualifications and opinions:

- Dr. Evans has treated no Medicaid patients and had no familiarity with the HLD score sheet prior to his work in this case.[115]
- For decades in Texas Medicaid practice, prior authorization was granted and benefits paid based on an interpretation of the definition of ectopic eruption that was more expansive than the one employed by Dr. Evans in his review of the Harlingen Family Dentistry (HFD) cases.[116]

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[113] Tr. Vol. 4 at 83-84.

[114] Tr. Vol. 4 at 30.

[115] Pet. Ex. 75 and 75.01; the Commission's Order in *Harlingen* (Oct. 10, 2012), Finding of Fact No. 29.

[116] Pet. Ex. 75 and 75.01; the Commission's Order in *Harlingen* (Oct. 10, 2012), Finding of Fact No. 31.

- Dr. Evans' view of ectopic eruption and his scoring of the patients at issue lack credibility, reliability, and indicia of reliability, and do not verify the allegations of fraud against HFD.[117]

- There is no evidence that is credible, reliable, or verifying, or that has indicia of reliability, that a fraudulent lack of dysfunction existed among the 85 HFD patients reviewed by Dr. Evans.[118]

Because Dr. Evans failed to testify in this case, his qualifications to render an opinion upon the scoring of ectopic eruption using the Texas Medicaid HLD score sheet remain unproven. Therefore, his expert report and conclusions are accorded no weight by the ALJs.

b. Dr. Tadlock

After imposing the payment hold, HHSC-OIG retained Dr. Tadlock to review ADC's HLD score sheets and supporting diagnostic materials previously reviewed by Dr. Evans.[119] Dr. Tadlock has assisted in scoring Medicaid patients at Baylor, but he has no Medicaid patients of his own.[120] Dr. Tadlock scored all 63 of the ADC patients, and in 62 of the cases, he scored the patient below the 26-point threshold.[121]

Dr. Tadlock also reviewed ADC's scores for 59 of the 63 patients.[122] He initially said there were no ADC HLD score sheets for Patients 10, 44, 51, and 53.[123] He subsequently admitted that Patients 10, 44, 51, and 53 did have ADC HLD score sheets, although they may not have been in the patient files he reviewed.[124] The Manual allows three points for each ectopically erupted tooth. For 58 of the 59 cases for which he had ADC score sheets,

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[117] Pet. Ex. 75 and 75.01; the Commission's Order in *Harlingen* (Oct. 10, 2012), Finding of Fact No. 33.

[118] Pet. Ex. 75 and 75.01; the Commission's Order in *Harlingen* (Oct. 10, 2012), Finding of Fact No. 34.

[119] Dr. Tadlock's expert report, Res. Ex. 9, was not written until February 20, 2013. Tr. Vol. 1 at 183.

[120] Tr. Vol. 1 at 132, 187.

[121] Tr. Vol. 1 at 183; Res. Ex. 9. Only Patient 15 met the 26-point threshold.

[122] Res. Ex. 49.

[123] Tr. Vol. 1 at 165-169; Res. Ex. 49.

[124] Tr. Vol. 1 at 224-227, 235.

Dr. Tadlock determined that ADC misrepresented the score for ectopic eruptions in order to reach the 26-point threshold for orthodontic care.[125]

To prove its fraud allegation, HHSC-OIG, through Dr. Tadlock, contrasted ADC's determination that 100% of the 63 cases warranted prior authorization for orthodontic treatment with Baylor's requests for prior authorization. According to Dr. Tadlock, of the approximately 700 Medicaid patients Baylor had examined for orthodontic treatment, approximately 25 or 26 (3.5%) were approved for braces.[126] Although Dr. Tadlock requested information from HHSC-OIG regarding the total number of Medicaid patients examined by ADC from November 2008 through August 2011, HHSC-OIG did not provide that information.[127]

Dr. Tadlock admitted that he did not use the Manual's definition, but rather used a more restrictive definition of ectopic eruption. He did not render an opinion regarding the accuracy of ADC's scoring based upon the Manual's definition of ectopic eruption.

c. Dr. Kanaan

Dr. Kanaan does not use the HLD Index to diagnose or treat his private-pay or Medicaid patients.[128] He uses the definition of ectopic eruption contained in the Manual only when scoring patients for Medicaid dental benefits. Of the 27 patients he scored that were included in the HHSC-OIG's sample, 23 had eight ectopic teeth in the same location.

Rebutting the claim that ADC qualified 100% of the patients for orthodontic treatment, Dr. Kanaan pointed out that Dr. Tadlock and HHSC-OIG have a fatal flaw in their comparison of ADC's prior authorization request rate as compared to Baylor's request rate. To properly compare Baylor's rate with ADC's rate, he argued one would have to compare ADC's total prior authorization requests against the total number of Medicaid patients ADC evaluated.[129]

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[125] Res. Ex. 9.

[126] Tr. Vol. 1 at 130-131, 229.

[127] Tr. Vol. 1 at 229-230.

[128] Tr. Vol. 3 at 16-17.

[129] Tr. Vol. 3 at 140.

d. Experts' Testimony Regarding Patients

The experts' testimony only discussed in detail a small number of the 63 patients. Moreover, the experts' testimony did not always address the same patients. Dr. Kanaan testified about Patients 36, 37, 42, 43, and 47.[130] Dr. Tadlock testified about Patients 1, 6, 10, 28, 42, 43, 54, and 57.[131] With respect to the HLD scores focusing on ectopic eruption, Dr. Nazari's testimony was limited to comparing ADC's scores with Dr. Tadlock's scores for Patients 13, 15, 16, 19, 25, 29, 35, 61, and 62.

As to these patients, Dr. Kanaan opined that each qualified under the criteria in the Manual. He explained that for Patient 36 he performed a comprehensive examination, including a visual intraoral examination, x-rays, and cephalometric[132] measurements/tracings.[133] Although Patient 36's teeth appear to be straight on the x-rays, he testified that the cephalometric measurements showed teeth slanting outside the long axis of the alveolar ridge on both top and bottom beyond the normal range.[134] In his opinion, Patient 36 had a severe handicapping malocclusion.[135]

Turning to Patient 37, Dr. Kanaan testified that the panoramic x-ray showed that the patient was missing two lateral teeth.[136] Additionally, while one tooth appeared to be straight, it had drifted far to the left.[137] Based his examination, the x-rays, and the cephalometric measurements, Dr. Kanaan concluded that Patient 37 had a severe handicapping malocclusion and that the patient might require surgery.[138] Patient 42, Dr. Kanaan explained, scored eight

[130] Dr. Kanaan stated his HLD scores for Patients 2, 5, 6, 7, 8, 9, 18, 20, 21, 24, 25, 28, 29, 34, and 35, but provided no additional testimony about these patients. Therefore, the ALJs do not discuss these patients.

[131] Patients 42 and 43 were the only patients addressed by more than one orthodontic expert in their testimony.

[132] Cephalometric is frequently referred to as "ceph." The hearing transcript uses "CEF."

[133] Tr. Vol. 3 at 147.

[134] Tr. Vol. 3 at 147-148; 152-153.

[135] Tr. Vol. 3 at 149.

[136] Tr. Vol. 3 at 156.

[137] Tr. Vol. 3 at 156.

[138] Tr. Vol. 3 at 156.

ectopic teeth for 24 points and four points for an open bite.[139] He pointed out that in the frontal photographs of this patient, the front teeth appear to be almost straight. However, the profile photographs showed that the teeth outside of the bone and that "the lips are noncompetent."[140] Dr. Kanaan testified that the cephalometric measurements confirmed his findings, including that the upper front teeth were biting over the bottom teeth. As a result, he determined that Patient 42 had a severe handicapping malocclusion.[141] Similarly, Patients 43 and 47 appeared to have straight teeth, but the x-rays and cephalometric measurements showed conditions causing severe handicapping malocclusions.[142]

Dr. Tadlock testified specifically to Patient 1, 6, 10, 28, 42, 43, 54, and 57. According to Dr. Tadlock, none of these patients qualified for orthodontic treatment with the exception of Patient 10 and 43. Dr. Tadlock opined that Patients 1, 6, 28, 54, and 57 had no ectopic front teeth and did not have severe handicapping malocclusion. After reviewing Patient 10's x-ray, Dr. Tadlock agreed that the x-ray looked "gnarly,"[143] and that Patient 10 qualified for interceptive treatment without meeting the 26-point threshold. He also conceded that the patient had two impacted teeth.[144]

As to Patient 42, while Dr. Tadlock determined the patient had two ectopic canine teeth, he concluded that the child did not have a severe handicapping occlusion.[145] However, Dr. Tadlock testified that there was some subjectivity in scoring this patient's teeth.[146] For Patient 43, Dr. Tadlock conceded that he missed an obvious ectopic tooth that was transposed

[139] Tr. Vol. 3 at 64; Pet. Ex. 64, Tab 43. ADC also scored and diagnosed an open bite.

[140] Tr. Vol. 3 at 153-154.

[141] Tr. Vol. 3 at 154-155.

[142] Pet. Ex. 64, Tabs 43 and 47; Tr. Vol. 3 at 159; 161-162. Patient 43's panoramic x-ray showed two front teeth leaning to the patient's left. Patient 47's cephalometric measurements showed that the upper incisors were biting the patient's lips.

[143] Tr. Vol. 1 at 215; Pet. Ex. 64, Tab 10.

[144] Tr. Vol. 1 at 213-216.

[145] Tr. Vol. 1 at 163-164.

[146] Tr. Vol. 1 at 163-164.

and probably damaging the lower tooth.[147] He also conceded that ADC properly scored the ectopic tooth and that ADC's diagnosis correctly included impacted teeth.[148]

e. Dr. Nazari

Dr. Nazari was questioned regarding the documentation for select patients from the 63 cases sampled by HHSC-OIG.[149] While Dr. Tadlock opined that these patients failed to qualify for Texas Medicaid orthodontic treatment, Dr. Nazari testified that ADC's score on the HLD index was accurate and that the patients qualified for Texas Medicaid orthodontic treatment. He further testified that unlike Dr. Tadlock, in each of these cases he used the Manual's definition of ectopic eruptions to score the patients.

f. Drs. Orr and Ornish

ADC's experts, Drs. Orr and Ornish, scored the ADC patients using the Manual's definition of ectopic eruption. While their scores did not always confirm the ADC scores, they were generally similar. Because the Manual's definition is not precise, these differences can be attributed to professional judgment. These differences in professional judgment do not prove fraud or intentional inflated scoring by ADC.

At the hearing, HHSC-OIG raised questions about Dr. Orr's credibility. The testimony of Drs. Orr and Ornish is cumulative of the testimony of Drs. Nazari and Kanaan about the Manual and adds no additional information. Their testimony only serves to confirm the subjective nature of scoring and generally supports the position that ADC's patients qualified for treatment. Therefore, the ALJs do not rely upon Drs. Orr and Ornish's testimony and find it unnecessary to further address their testimony in this Proposal for Decision.

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[147] Tr. Vol. 1 at 219-220.

[148] Tr. Vol. 1 at 218.

[149] Dr. Nazari specifically compared ADC's HLD score to Dr. Tadlock's HLD score for Patients 13, 15, 16, 19, 25, 29, 35, 61, and 62.

B. ALJs' Analysis

While HHSC-OIG alleged that ADC was filing inflated HLD score sheets because it knew that TMHP was not properly performing its prior authorization responsibilities, there is no credible evidence to support this assumption. The ALJs agree with Dr. Kanaan regarding the flaw in the ADC and Baylor prior authorization rate comparison. Because Dr. Tadlock and HHSC-OIG only looked at the 63 ADC cases for which prior authorization was sought and failed to include the total number of Medicaid patients examined by ADC, it is not a proper comparison and provides no useful information with respect to HHSC-OIG's fraud allegation.

Further, the statistical data relied upon by HHSC-OIG to support its payment hold failed to show that ADC was inflating its HLD score sheets. The ALJs find that the reduction in the volume of ADC's Medicaid patients and prior authorization requests was due to the following causes: (1) the holiday season; (2) the January 1, 2012 change in the definition of ectopic eruption; (3) the January 2012 to March 2012 stay imposed on providers' requests for prior authorizations;[150] (4) the financial impact of the payment hold; and (5) the initial confusion caused by the change to a managed care system. Consequently, the ALJs find unpersuasive HHSC-OIG's conclusion that the reduction in volume of ADC's prior authorization requests and Medicaid patients demonstrated that ADC had previously inflated its HLD scores or submitted false information to TMHP. Just as HHSC-OIG failed to demonstrate that a reduction in volume proved fraud, so too it failed to substantiate its assumption that a significant increase in utilization beginning in 2008 indicated fraud.

HHSC-OIG initially concluded that ADC committed fraud relying, in significant part, on Dr. Evans' HLD scoring analysis. As previously addressed, the ALJs accorded no weight to Dr. Evans' opinions. At the hearing, HHSC-OIG relied upon Dr. Tadlock to support its fraud allegation. Dr. Tadlock failed to use the Manual's definition of ectopic eruption in scoring the 63 ADC patients. Failing to follow the Manual's definition of ectopic eruption for scoring on the HLD renders unhelpful the opinions and conclusions drawn by Dr. Tadlock as to both ADC's HLD scoring and Dr. Tadlock's own scoring.

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[150] Pet. Ex. 81 at 45 (May/June 2012 Texas Medicaid Bulletin, No. 241).

Dr. Tadlock's testimony had additional shortcomings. Although crossbite, interceptive treatment,[151] trauma care, and cleft palate, were exceptions to the 26-point requirement to qualify for Texas Medicaid treatment, Dr. Tadlock failed to consider these exceptions when doing his review[152] and, consequently, he missed two exceptions.[153] Dr. Tadlock also admitted to several other shortcomings in his review of ADC's scoring and in his scoring:

- He incorrectly assumed all the cases were for comprehensive braces.[154]
- He missed a tooth that was clearly ectopic, even by his definition.[155]
- He did not review the chart notes provided to him for the 63 ADC patients he reviewed because HHSC-OIG instructed him to review only the HLD score sheets.[156]
- He failed to properly score anterior crowding.[157]

In contrast, Drs. Kanaan and Nazari had extensive experience with Texas Medicaid and properly utilized the Manual in scoring the HLD Index. The ALJs find the testimony and opinions of Drs. Kanaan and Nazari credible. HHSC-OIG attempted to impeach Dr. Kanaan's testimony by pointing out that he treated 6,500 Medicaid patients at ADC during the relevant period rather than the 2,000-3,000 Medicaid patients that Dr. Kanaan estimated.[158] HHSC-OIG's impeachment fails because Dr. Kanaan was asked about the number of Medicaid patients he personally treated at ADC. The 6,550 figure used by HHSC-OIG represents the cumulative total

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[151] Dr. Tadlock explained that interceptive treatment is treatment for children with some baby teeth whose dental condition requires interception to avoid greater problems in the future. Tr. Vol. 1 at 185-186.

[152] Dr. Tadlock believes that a provider would not use an HLD sheet for crossbite, and would not code crossbite therapy under D-8080. Tr. Vol. 1 at 233-234.

[153] Tr. Vol. 1 at 186-187.

[154] Tr. Vol. 1 at 216-217.

[155] Tr. Vol. 1 at 209-210, 217-220.

[156] Tr. Vol. 1 at 212-213, 217.

[157] Tr. Vol. 1 at 211-212.

[158] Tr. Vol. 3 at 173-174; Vol. 3 at 268-269.

of ADC's Medicaid patients approved for prior authorization during the relevant time. These patients were not all scored by Dr. Kanaan; Dr. Nazari also scored HLD score sheets.[159]

In summary, the ALJ's find that HHSC-OIG failed to present evidence of a credible allegation of fraud that ADC inflated its scoring of the HLD Index for any of these 63 patients.

VI. NON-FRAUDULENT VIOLATIONS

A. Record and Document Retention

As previously noted, the Commission's rules also authorize HHSC-OIG to impose a payment hold after determining that prima facie evidence exists of non-fraudulent violations.[160] HHSC-OIG alleged that ADC failed to maintain required records and materials in the patient files for five years in violation of 1 Texas Administrative Code § 371.1617(1)(K) and (2)(A). Therefore, HHSC-OIG contended that the payment hold is warranted.[161]

At the beginning of the hearing, HHSC-OIG alleged that ADC failed to maintain six dental models, five HLD score sheets, and the documentation for three dates of service. Conversely, Dr. Nazari submitted that although a few items might be missing now, ADC's HLD score sheets and supporting documentation were submitted to TMHP. If they had not been submitted, ADC would not have received prior authorization to perform the services.[162] Nevertheless, Dr. Nazari agreed that when HHSC-OIG came to collect the 63 patient files in November 2011, ADC was unable to locate the dental models[163] for Patients 1, 2,[164] 4, 13, 32, 43, 45, and 48;[165] the HLD score sheets for Patients 25, 44, 48, 51, and 53;[166] the pre-treatment

[159] *See, e.g.*, Tr. Vol. 4 at 94-102; Pet. Ex. 64.

[160] 1 Tex. Admin. Code § 371.1703(b)(5) (2005).

[161] 1 Tex. Admin. Code § 371.1617(5)(A) and (G) (2005).

[162] Tr. Vol. 4 at 22.

[163] Models or molds are plaster casts made from an impression taken of the patient's mouth. Effective February 1, 2005, providers were no longer required to submit models when requesting prior authorization. This remained the Commission's policy until October 2011. Tr. Vol. 1 at 73; Pet. Ex. 70 at 35.

[164] The records show the dental molds for Patient 2were shipped to Genesis Orthodontic Laboratory on April 1, 2009. Tr. Vol. 4 at 49.

[165] Tr. Vol. 4 at 40-42.

x-rays for Patients 22 and 48;[167] and the progress notes or treatment card for dates of service for Patients 2, 4, 5, 6, 7, and 8.[168]

There are several discrepancies between HHSC-OIG's opening statement and the evidence that the ALJs are unable to explain. With respect to the dental models, HHSC-OIG presented evidence on more patients (eight patients) than it represented in its opening were at issue (six patients). Because the allegations lack specific patient numbers in HHSC-OIG's complaint, the ALJs used the greater number in evaluating HHSC-OIG's case and find that ADC could not produce eight models when HHSC-OIG requested the files for 63 patients in November 2011.

As to the missing HLD score sheets, Dr. Nazari's testimony and Dr. Tadlock's testimony do not reconcile. Dr. Tadlock testified he did not see ADC score sheets for Patients 10, 44, 51, and 53 in the ADC files he reviewed.[169] Dr. Nazari makes no mention of Patient 10, and Dr. Tadlock makes no mention of Patients 25 and 48. The evidence established that ADC did not have the HLD score sheets in November 2011 for Patients 10, 44, 51, and 53.

Countering the allegation that there were missing progress notes or treatment cards, Dr. Nazari testified that although ADC submitted requests for prior authorization on behalf of Patients 2, 4, 5, 6, 7, and 8, these six patients never returned to ADC for treatment. For this reason, ADC had no treatment notes for these patients.[170]

B. Payment For Services And Items Not Reimbursable

HHSC-OIG accused ADC of submitting claims for reimbursement for services that were excluded from coverage.[171] Specifically, HHSC-OIG claimed that ADC improperly submitted and received payment for comprehensive orthodontic treatment (dental procedure code D8080)

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[166] Tr. Vol. 4 at 23, 26.

[167] Tr. Vol. 4 at 44-45.

[168] Tr. Vol. 4 at 44- 46, 53.

[169] Vol. 1, at 165-169, 224-227, 235; Res. Ex. 49.

[170] Tr. Vol. 4 at 76-77.

[171] 1 Tex. Admin. Code §§ 371.1617(1)(K), (5)(A), and (G) (2005).

for three patients who were not yet 12 years old, or still had some primary teeth,[172] or both. Patient 15 was nine years old and Patients 56 and 60 were ten years old when ADC submitted prior authorization requests on their behalf for comprehensive orthodontic treatment. All three still had some primary teeth.[173]

ADC's prior authorization request for interceptive treatment for Patient 15 showed a diagnosis of "Class II molar malocclusion," and included the patient's age.[174] Both Drs. Nazari and Tadlock agreed that Patient 15 met the minimum HLD score requirement.[175] Patient 15 qualified for orthodontic benefits.[176] Patient 56's diagnosis was "Class I, spacing, need way to manage space."[177] ADC's request for prior authorization for interceptive treatment noted the child's age and that the child still had three primary teeth; despite this, TMHP approved the request.[178] Patient 60 had three primary teeth and a diagnosis of "CL II, molar malocclusion."[179] ADC's request for prior authorization for interceptive treatment noted the child's age and that the child still had three primary teeth. TMHP approved ADC's prior authorization request.[180]

C. ALJs' Analysis of Non-Fraudulent Program Violations

The disputed issue is whether ADC complied with the Manual and 1 Texas Administrative Code § 371.1617(2)(A) by maintaining the Medicaid patient records for 5 years. Contrary to ADC's position, this does not require a finding by TBDE that a dentist has violated TBDE rule 108.8, only that the provider violated the Manual's retention provision. Section 1.4.3 of the Manual's general provisions governing the retention of records required all providers to retain the documentation related to the services provided under Medicaid for a minimum of five

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[172] Primary teeth are commonly referred to as baby teeth or deciduous teeth.

[173] Pet. Ex. 15 at 15-0023; Pet. Ex. 56 at 56-0015; Pet. Ex. 60.

[174] Pet. Ex. 15 at P-00244; Pet. Ex. 64, Tab 15.

[175] Tr. Vol. 4 at 62-63; Pet. Ex. 64, Tab 15; Res. Ex. 9 at 1; Res. Ex. 11 at 15.

[176] Tr. Vol. 4 at 61-64.

[177] Pet. Ex. 64, Tab 56.

[178] Tr. Vol. 4 at 65-66; Pet. Ex. 64, Tab 56.

[179] Pet. Ex. 64, Tab 60.

[180] Tr. Vol. 4 at 66-67.

years.[181] Additionally, Section 19.13 of the 2008 Manual dictated, "[a]ll documentation must be maintained in the client's record for a period of five years to support the medical necessity at the time of any post-payment utilization review."[182]

ADC was also contractually required to keep patient records, including the dental charting; diagnoses; treatment plan; study models, casts, molds, impressions, if applicable; progress and completions notes; and prescriptions, among other things, for a minimum of five years. The evidence shows that in November 2011 when HHSC-OIG appeared at ADC's office, ADC was unable to locate eight dental models, four HLD score sheets, and two pre-treatment x-rays. However, the evidence also established that when ADC filed its request for prior authorization with TMHP, the requests included the HLD score sheets.[183] The ALJs find that HHSC-OIG presented prima facie evidence that ADC failed to comply with the record retention requirements.

As to HHSC-OIG's allegation that ADC failed to maintain progress notes or treatment cards for dates of service for Patients 2, 4, 5, 6, 7, and 8, the ALJs find that HHSC-OIG failed to present prima facie evidence supporting this allegation. Although ADC submitted prior authorization requests for these patients after the initial scoring consultation, these six patients never returned to ADC for treatment and no progress notes or treatment cards were warranted.

HHSC-OIG also accused ADC of committing program violations by submitting claims for reimbursement for services that were excluded from coverage. The evidence proves that Patients 15, 56, and 60 were eligible for interceptive treatment under Texas Medicaid. The Manual expressly allows coverage for children with retained deciduous teeth who had gross malocclusion that would benefit from early treatment by exempting them from meeting the age requirement.[184] There is no evidence that is credible, reliable, or verifiable, or that has indicia of

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[181] Res. Ex. 14 at 1-8 ¶1.2.3 (2008 Manual).

[182] Res. Ex. 14 at 19-8 ¶19.13 (2008 Manual).

[183] ADC objected to consideration of any allegations regarding the pre-treatment x-rays claiming that HHSC-OIG failed to plead this allegation. However, HHSC-OIG pleaded that ADC failed to maintain patient records that included, but were not limited to, certain items. The ALJs overruled ADC's objection.

[184] Res. Ex. R-14 at 19-36 ¶19.18.1 (2008 Manual).

reliability, that ADC committed program violations by submitting claims for reimbursement for services that were excluded from coverage. On this issue, HHSC-OIG failed to present prima facie evidence in support of its allegation.

Although not specifically pleaded, in its written closing argument, HHSC-OIG claimed that ADC was missing extraction requests for Patients 15, 23, 56, and 60.[185] However, when Dr. Narazi was questioned about whether ADC had to have a "proper extraction request" in the patient's file, Dr. Narazi said, "No sir." The citation provided by HHSC-OIG in its closing argument, Res. Ex. 15 at 19-37, does not reference an extraction request. The ALJs find that HHSC-OIG failed to demonstrate that ADC did not comply with the Manual by failing to a "proper extraction request."

VII. ALJS' ANALYSIS REGARDING PAYMENT HOLD

Texas Human Resources Code § 32.0291, discussed above, provides that the Commission may impose a payment hold if there is reliable evidence of fraud or willful misrepresentation. Commission Rule 371.1703(b), provides for payment holds, prior to the completion of an investigation, based on "prima facie" evidence of fraud or willful misrepresentation and for other violations.

HHSC-OIG has no basis for a payment hold based upon fraud or willful misrepresentation in this case.

For non-fraudulent program violations, HHSC-OIG also has a variety of other remedies that it could impose against a provider for program violation. These include educating providers, administrative sanctions, recoupment actions, and exclusion from the Texas Medicaid program.[186] HHSC-OIG can also dismiss a case.[187] In this case, HHSC-OIG proved a technical violation for ADC's failure to maintain applicable records in the patients' file for five years as required by the Manual. While HHSC-OIG has authority under 1 Texas Administrative Code

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[185] HHSC-OIG's Post Hearing Brief and Closing Argument at 48.

[186] Tr. Vol. 3 at 233-234.

[187] Tr. Vol. 3 at 233.

§ 371.1703 to maintain a payment hold based on prima facie evidence of other violations, a payment hold should be reasonably related to the magnitude of the problem indicated by the reliable evidence. Program violations range from "very innocuous" to "very important."[188]

HHSC-OIG proved that eight dental molds, four HLDs, and two pre-treatment x-rays could not be found in the patients' files in November 2011. However, the evidence in this case also established that the records and models were created by ADC and transmitted to TMHP. Thus, ADC's violations are technical violations and do not rise, based upon this record, to a level of substantive concern. Therefore, the ALJs find no basis for a payment hold being imposed by HHSC-OIG and recommend the payment hold be discontinued.

VIII. FINDINGS OF FACT

Background

1. Behzad Nazari, D.D.S., has owned Antoine Dental Center (ADC) since 1998. ADC has two dental clinics in Houston, Texas, that treat Medicaid and private pay clients.

2. Between November 1, 2008, and August 31, 2011, ADC provided dental and orthodontic services to Medicaid patients as a Texas Medicaid Provider holding Provider Identification Nos. 1905432, 2187031, 1952657, and 0908162.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.

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188 Tr. Vol. 3 at 220.

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. 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 Labio-lingual Deviation (HLD) score sheet contained in the Manual to determine whether orthodontic services qualified for Medicaid coverage.

14. The Manual required providers to complete and submit the HLD score sheet to TMHP together with a prior authorization request and the supporting clinical materials including the treatment plan, cephalometric radiograph with tracing models, facial photographs, radiographs, the model (or cast) of the patient's teeth if a model was made, and any additional pertinent information to evaluate the request.

15. The HLD Index is an index measuring the existence or absence of handicapping malocclusion and its severity, and is a tool used by Medicaid to measure whether a patient qualifies for the public funding program. It is not intended to be a diagnostic or treatment tool.

16. The Manual described the categories of the HLD Index, and instructed providers on how to score those categories.

17. The HLD score sheet assigned a certain number of points for the following observed conditions: cleft palate, severe traumatic deviations, overjet, overbite, mandibular protrusion, open bite, ectopic eruption, anterior crowding, and labio-lingual spread in millimeters.

18. Orthodontic services provided solely for cosmetic reasons were not covered under the Texas Medicaid program.

19. Although Texas Medicaid generally restricted orthodontic treatment to children 12 years of age or older who no longer had primary teeth, a provider could request that TMHP

approve prior authorization for interceptive treatment or for treatment for a child who qualified for another exception under the program.

20. In general, orthodontic benefits were limited to the treatment of children 12 years of age or older with a severe handicapping malocclusion. If the HLD Index score did not meet the 26-point threshold, a provider could submit a narrative to establish the medical necessity of the treatment.

21. TMHP was responsible for reviewing the filed material to evaluate whether the orthodontic services were medically necessary before granting prior authorization.

22. The Manual clarified that prior authorization of an orthodontic service did not guarantee payment. To receive payment, the provider still had to show that the orthodontic procedure was medically necessary under the terms and conditions of the Manual.

23. After ADC provided the orthodontic treatment to the patients in this case, TMHP approved payment.

2008 HHSC-OIG Audit of TMHP

24. On August 29, 2008, HHSC-OIG issued a performance audit report regarding TMHP's prior authorization process for the period between September 1, 2006, and March 31, 2008, finding that TMHP's prior authorization process did not comply with the Manual (the 2008 audit report).

25. In the 2008 audit report, HHSC-OIG found that TMHP's prior authorization staff failed to review the supporting material submitted by providers with their prior authorization requests, as required, and that TMHP's staff did not have the dental credentials necessary to evaluate whether the supporting documentation submitted by providers supported the HLD score.

26. ADC was unaware of the 2008 audit report and HHSC-OIG's assertion that TMHP was not properly performing prior authorization evaluations.

HHSC-OIG's Investigation of ADC

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, and in each case the patient scored 26 or more points. The greatest number of points was associated with the category of "ectopic eruption."

30. Dr. Evans concluded that in all 63 cases, the clinical records did not support the scoring on the HLD score sheets submitted with the prior authorization requests because of the score assigned to the ectopic eruption category. Dr. Evans did not testify in this matter.

31. Although HHSC-OIG represented that its field investigators interviewed ADC's office staff, dentists, and the patients and their parents/guardians, it did not present this evidence during the hearing.

32. Based in large part on Dr. Evans' conclusions, on April 4, 2012, HHSC-OIG issued a letter to ADC notifying ADC that it was imposing a 100% payment hold on all future Medicaid reimbursements due to a credible allegation of fraud for claims ADC submitted from November 1, 2008 through August 31, 2011.

33. ADC timely requested a hearing to contest the payment hold, and the matter was referred to the State Office of Administrative Hearings (SOAH) on November 7, 2012.

34. HHSC-OIG referred ADC to the Medicaid Fraud Control Unit of the Office of the Attorney General (MFCU), and on March 29, 2012, MFCU opened an investigation.

35. On January 15, 2013, HHSC-OIG issued its First Amended Notice of Hearing to ADC. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short plain statement of the matters asserted.

36. The hearing on the merits was held May 28 through 31, 2013, before Administrative Law Judges Catherine C. Egan and Howard S. Seitzman at the State Office of Administrative Hearings (SOAH) in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. ADC appeared through its attorneys of record, J.A. Tony Canales, Hector Canales, Robert M. Anderton, Philip H. Hilder, William B. Graham, James G. Rytting, and Thomas Watkins. HHSC-OIG was represented by outside counsel Dan Hargrove, Caitlyn Silhan, James R. Moriarty, Ketan Kharod; by Assistant Attorneys General Raymond C. Winter and Margaret M. Moore, from the Office of Attorney General of Texas, and by Enrique Varela and John R. Medlock, from HHSC-OIG.

Ectopic Eruption

37. In the 2008 through 2011 Manuals (Manuals), the HLD index described the term "ectopic eruption" as "an unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge." The Manuals instructed providers not to include (score) teeth from an arch if the provider counted the arch in the category for

anterior crowding. For each arch, the Manual further instructed that either the ectopic eruption or anterior crowding could be scored, but not both.

38. The Manuals' references to high labial cuspids and teeth grossly out of the long axis of the alveolar ridge were nonexclusive examples of ectopic eruption.

39. The Manuals' definition of ectopic eruption in the 2008 through 2011 Manual required subjective judgment to interpret.

40. The Manuals' 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.

41. The language in the Manuals provided a definition of ectopic eruption solely for use in scoring the HLD index to qualify for payment.

42. 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.

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 only one patient with ectopic eruptions that scored 26 points, Patient 15.

45. Dr. Tadlock did not apply the Manuals' definition of ectopic eruption in scoring the HLD Index for the 63 ADC patients.

46. Dr. Nazari was a credible witness and properly utilized the Manuals' definition of ectopic eruption in scoring the HLD Index.

47. Wael Kanaan, D.D.S., an orthodontist who worked with ADC, was a credible witness and properly utilized the Manuals' definition of ectopic eruption in scoring the HLD Index.

Fraud and Willful Misrepresentations

48. 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 Texas Medicaid benefits for patients or to obtain Texas Medicaid payments.

49. 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.

50. There is no evidence that is credible, reliable, or verifying, 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.

Failure to Maintain Records

51. When HHSC-OIG arrived at ADC in November 11, 2012, and asked for 63 case files, prima facie evidence exists that ADC could not locate eight dental models, four HLD score sheets, and two pre-treatment x-rays.

52. ADC forwarded the HLD score sheets and supporting documentation to TMHP when 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.

Services and Items Not Reimbursable

54. 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.

55. Patient 15, 56, and 60, were eligible for interceptive treatment under Texas Medicaid.

Payment Hold

56. Program violations range from "very innocuous" to "very important."

57. ADC's violation is a technical violation and based upon this record does not rise to a level of substantive concern.

IX. 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. HHSC-OIG had the burden of proof.

5. It is an unlawful act to knowingly make or cause to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized. Tex. Hum. Res. Code § 36.002(1) (2003).

6. The term "knowingly" means that the person has knowledge of the information, acts with conscious indifference to the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. Proof of the person's specific intent to commit an unlawful act under § 36.002 is not required to show that a person acted "knowingly." Tex. Hum. Res. Code § 36.0011 (2003).

7. "Fraud" is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person, including any act that constitutes fraud under applicable federal or state law. Tex. Gov't Code § 531.1011(1) (2011).

8. HHSC-OIG must impose a hold on payment of claims for reimbursement submitted by a provider on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or willful misrepresentation under the state Medicaid program. 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. "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. 42 C.F.R. § 455.2 (2011).

11. HHSC-OIG may impose a payment hold on future claims submitted by a provider if there is reliable evidence that the provider has committed fraud or willful misrepresentation regarding a claim for reimbursement under the medical assistance program. Tex. Hum. Res. Code § 32.0291(b)(2003).

12. In a SOAH hearing on a payment hold, HHSC-OIG must make a prima facie showing that the evidence relied upon in imposing the payment hold is relevant, credible, and material to the issue of fraud or willful misrepresentation. Tex. Hum. Res. Code § 32.0291(c) (2003).

13. HHSC-OIG lacks authority to maintain the payment hold against ADC for alleged fraud or misrepresentation. Tex. Gov't Code § 531.102(g)(2) (2011); 42 C.F.R. § 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).

14. A payment hold should be reasonably related to the magnitude of the violation.

15. The prima facie evidence established that ADC committed program violations by failing to maintain certain patient records for the required five years. 1 Tex. Admin. Code §§ 371.1703(b)(5),(6); 371.1617(2)(A), (5)(A) and (G)(2005).

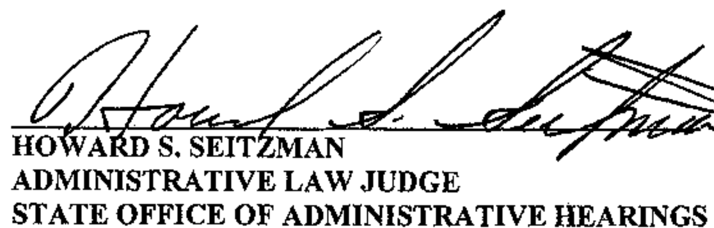
16. These technical violations are very limited in number and are innocuous; therefore, they do not warrant a payment hold in this case.

X. RECOMMENDATION

The ALJs recommend that the payment hold against Antoine Dental Center be discontinued.

SIGNED November 4, 2013.

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS



HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

PLEASE PRINT CLEARLY:

Client Name:	Date of birth:	Medicaid ID:
Address: *(Street/City/County/State/Zip Code)*		

CONDITIONS OBSERVED				HLD SCORE
Cleft Palate			Score 15	
Severe Traumatic Deviations Trauma/Accident related only			Score 15	
Overjet in mm. *Minus 2 mm.* *Example: 8 mm. – 2 mm. = 6 points*				=
Overbite in mm. *Minus 3 mm.* Example: 5 mm. – 3 mm. = 2 points				=
Mandibular Protrusion in mm. See definitions/instructions to score (previous page)			x5	=
Open Bite in mm. See definitions/instructions to score (previous page)			x4	=
Ectopic Eruption (Anteriors Only) *Reminder: Points cannot be awarded on the same arch for Ectopic Eruption and Crowding*			Each tooth x3	=
Anterior Crowding *10 point maximum total for both arches combined*	Max.	Mand.	= 5 pts. each arch	=
Labiolingual Spread in mm.				
TOTAL				=
Diagnosis				=

Diagnosis	For TMHP use only Authorization Number
Examiner:	Recorder:
Provider's Signature	

Please submit this score sheet with records

APPENDIX 1

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