**CAUSE NO. 529-12-3180**

| | | |
|---|---|---|
| **HARLINGEN FAMILY DENTISTRY** | § | **BEFORE THE STATE OFFICE** |
| | § | |
| | § | |
| **VS.** | § | **OF** |
| | § | |
| **TEXAS HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INSPECTOR GENERAL** | § | **ADMINISTRATIVE HEARINGS** |

**TEXAS HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INSPECTOR GENERAL'S EXCEPTIONS TO PROPOSAL FOR DECISION**

TO THE HON. SHANNON KILGORE, ALJ:

The Texas Health and Human Services Commission, Office of Inspector General (OIG), respectfully files its exceptions to the proposal for decision.

## I. EXCEPTIONS TO THE FINDINGS OF FACT

A. Finding of Fact Number 35.

OIG excepts to Finding of Fact No. 35 because it disregards two of the requisite mental states for establishing fraud. The ALJ correctly noted in the discussion of applicable law that Medicaid fraud may be proved by demonstrating intent, knowledge, reckless disregard, or conscious indifference.[1] But the ALJ's rationale for Finding of Fact Number 35 is limited to eonsiderations of intent and knowledge only.[2]

The ALJ failed to address the mental states of reckless disregard or conscious indifference. In so doing, the ALJ held the agency to a higher standard of proof than the law requires.

[1] PFD: 7.
[2] PFD: 27-28 (finding that the evidence is not "suggestive of knowing or intentional fraud or misrepresentation.")

The ALJ correctly notes in the rationale that the state must demonstrate prima facie evidence of its allegations.[3] The prima facie standard is defined as requiring the "minimum quantum of evidence necessary to support a rational inference that the allegation of fact is true." *In re E.I. DuPont de Nemours*, 136 S.W.3d 218, 223 (Tex. 2004); *In re Christus Health Southeast Texas*, 167 S.W.3d 596, 599-600 (Tex. App. -- Beaumont 2005, orig. proceeding).

Certain facts are not contested. For example, it is undisputed Harlingen Family Dental (HFD or Petitioner) submitted incorrectly scored HLD score sheets – HFD's own expert conceded over 9% of 85 score sheets were incorrect.[4] It is undisputed that HFD paid its two full time orthodontists a commission based on collections and that Petitioner's annual total Medicaid reimbursement was approximately $5 million.[5] It is undisputed that Harlingen Family Dental overbilled the Texas Medicaid Program by at least $450,000 every year.

These facts support a rational inference that Petitioner exhibited reckless disregard – or at least conscious indifferenee - to Medicaid policy. Moreover, Petitioner was highly incentivized to remain indifferent to proper score sheet policy. The findings of fact should be modified to acknowledge the existenee of conscious indifference or reekless disregard and to result in a finding of Medicaid fraud.

B. Findings of Fact Numbers 26, 27, 28, 31, and 32.

OIG excepts to Findings of Fact Numbers 26, 27, 28, 31, and 32 because they are predicated on an incomplete excerpt from the applicable Medicaid policy. The ALJ disregarded all but the first five words of the definition of "ectopic eruption" in contradiction of the agency's longstanding policy interpretation.[6] In so doing, the court failed to consider the administrative

[3] PFD: 6.
[4] PFD: 34.
[5] PFD: 32.
[6] PFD: 18.

intent and objectives of the policy. *See* TEX. GOV'T CODE § 311.023(a)(1), (a)(6); *Dutchmen v. Texas DOT*, No. 03-11-00116-CV, slip op. at 7 (Tex. App. – Austin, Aug. 17, 2012, no pet. h.); *Gomez v. TEA*, 354 S.W.3d 905, 912-13 (Tex. App. – Austin 2011, pet. denied).

The ALJ acknowledges the definition and interpretation of "ectopic eruption" lie at the heart of this ease.[7] Yet the ALJ failed to eonsider the testimony of the witnesses who were most qualified to testify about the meaning and intent of that policy, utterly disregarding the opinion of the only orthodontist who was financially divorced from the outcome of both this proceeding and the HLD score sheets themselves. The ALJ's explanation for dismissing Dr. Evans' more than 40 years of orthodontic experience is that he has not treated Medicaid patients. The problem with this summary dismissal of more than four decades of experience is that it subsumes the belief that "ectopic eruption" is either a dental phenomenon unique to thc Medicaid population or that "ectopic eruption" is a term of art within the Medicaid provider community. No evidence exists that either is true.

Although the ALJ correctly notes Dr. Evans' opinion was the pivotal point in the State's determination that sufficient, eredible evidence of fraud existed to support a payment hold, the ALJ's other conclusions regarding the presence or absence of fraud fail to assess the totality of the circumstances. The ALJ writes "[t]hat HFD was a large and growing Medicaid utilizer is not, by itself, evidence of fraud."[8] The volume of utilization of Mcdicaid is nonetheless evidence. The ALJ acknowledges "that two providers at HFD were paid on commission,"[9] but improperly dismisses that evidence. All of these facts exist together. Thus, that a provider pays orthodontists based on the number of cases "bad" enough to warrant Medicaid treatment begs to be understood as an incentive to enhance or fabricate clinical findings to justify treatment.

[7] PFD: 14.
[8] PFD: 25.
[9] PFD: 25.

Yet even assuming the ALJ found little value in the OIG's retained expert, there is no explanation for ignoring the only two disinterested witnesses who might be authorized to speak on behalf of the agency. Dr. Altenhoff is a specialist in Medicaid dental policy and has worked with the State since the time of Dr. Orr's tenure.[10] She testified by deposition that the definition has not changed since the dates of service at issue in this proceeding.[11] She testified unequivocally that Medicaid policy did not include leaning or rotating teeth during the dates at issue.[12] She clearly stated that the 2011 explanation was nothing more than a clarification of the original definition.[13] Moreover, she suggested to orthodontic providers that they pull Google images of "ectopic eruption" for more guidance on what sort of abnormality would qualify for Medicaid coverage of orthodontic services.[14] In other words, an ectopic eruption has a common enough professional meaning that one need not even resort to learned treatises for examples – they are readily available on the internet. The State Medicaid Director also testified by deposition that the 2011 publication did not change the definition of ectopic eruption. He was clear in his testimony that the only related policy change in 2011 was the reinstated requirement to submit dental molds.[15] He testified that the Medicaid rules for scoring HLD sheets were clear prior to the 2011 publication.[16] These two staff members were employed by health and human service agencies during the dates of service in this case.

Yet the ALJ based her opinion on the testimony of Dr. Orr, a dentist who never practiced orthodontia, who left the agency in 2003, who admitted he consulted with orthodontists when he worked at NHIC when he found a troubling case and who was not on staff during the applicable

[10] Exhibit P-11: 6 (lines 11-17), 7 (lines 1-7), 22 (lines 10-15).
[11] Exhibit P-11: 14 (lines 15-20).
[12] Exhibit P-11:19 (lines 15-25), 20 (lines 1-5, 10-14).
[13] Exhibit P-11: 36 (lines 19-22), 37 (lines 1-18).
[14] Exhibit P-11: 11 (lines 9-15); 38 (lines 5-22).
[15] Exhibit P-10: 82 (lines 6-12).
[16] Exhibit P-10: 81 (lines 9-11).

dates.[17] Dr. Orr and Dr. Teegardin interpreted "unusual" to include any situation where the teeth are not all "lined up straight" or in ideal position.[18] But their definition of an "unusual pattern" incorporated even slight rotations and crowding, resulting in higher HLD scores. Therefore, their interpretation included cosmetic orthodontia, which is expressly prohibited.[19] As such, Dr. Orr's testimony squarely contradicted clear Medicaid policy that disallows orthodontia for cosmetic purposes.[20]

The ALJ found the policy is vague and unclear.[21] Even if one accepts that to be true, if there is vagueness, ambiguity, or room for policy determinations in a regulation, the law generally requires courts to defer to the agency's interpretation if it is reasonable. *TGS-NOPEC Geophysieal v. Combs*, 340 S.W.3d 432, 438 (Tex. 2011); *Dutchmen*, slip op. at 7. The ALJ did not defer to the interpretation of the agency's representatives. The ALJ did not explain why she thought the agency representatives' interpretation to be unreasonable. Instead, the ALJ disregarded their testimony. The ALJ's determination to rely on Dr. Orr and the Petitioner's employees while concomitantly disregarding all of the State's evidence required the ALJ to ignore the longstanding relationship between Dr. Orr and Dr. Villareal, ignore the financial incentives the petitioner's employee's had to score HLD sheets improperly, and ignore the clearly stated and undisputed policy and intent of the Medicaid program. This approach was unwarranted and constitutes a misapplication of the law to these facts and a misinterpretation of policy.

C. Findings of Fact Number 33, 34.

OIG excepts to Findings of Fact No. 33 and 34 because they impose a higher burden on

[17] RR2: 423 (line 7).
[18] RR2: 340 (lines 15-23); 410 (lines 6-9).
[19] PFD: 3.
[20] PFD: 3 (quoting Exhibit R-X at 68 as a provision of particular importance).
[21] PFD: 34, Finding of Fact Number 27.

the agency than is required by law. First, the findings improperly raised the state's burden by requiring the agency to look behind the validity of the expert's opinions in verifying whether the allegations may be credible.[22] Secondly, the ALJ's PFD shifted the burden of demonstrating handicap or dysfunction from the provider to the agency.[23] Third, thc ALJ improperly relieved the provider of its burden to demonstrate handicap by "deeming" dysfunction if a certain HLD score was submitted.[24] Finally, the ALJ requircd the agency's expert to prove an overpayment, in disregard of the fact that this was an interlocutory proeeeding and overpayment was not at issue.[25]

As previously discussed, the standard is prima facie evidence, which may be satisfied by the minimum quantum of evidence necessary to support a rational inferenee that the allegation of fact is true. *In re DuPont,* 136 S.W.3d at 223. Thus, the agency only needed to support a rational inference that the allegations were credible and that the ageney had reviewed the faets carefully and judiciously before imposing the hold.[26] Although the ALJ ultimately decided that the agency's expert misapprehended Medicaid policy; that was not the issue. The state was only required to take sufficient measures to verify the credibility of an allcgation. OIG acted in good faith to retain an expert with significant experience in orthodontia and he reviewed a large sample of cases. OIG learned from Dr. Altenhoff and Mr. Millwee that they believed Medieaid policy about ectopic eruptions to be clearly understood among practicing orthodontists. OIG was entitled to rely upon the representations of its expert in verifying the credibility *of the allegations*, and thus met its burden to support eontinuation of the payment hold.

Additionally, the ALJ's analysis shifted the burden to OIG to demonstrate that there was

[22] PFD: 25-26.
[23] PFD: 28.
[24] PFD: 25-26.
[25] PFD: 4.
[26] *See* PFD: 5-6.

no handicapping or dysfunction of the Medicaid clients. All Medicaid providers are responsible for maintaining adequate clinical documentation for supporting any services billed to Medicaid.[27] The failure to maintain adequate clinical documentation constitutes a program violation. *See* 1 TEX. ADMIN. CODE § 371.1617(a)(2)(A). A program violation justifies recoupment of Medicaid dollars. *See* 1 TEX. ADMIN. CODE §371.1703(b)(5). Yet the ALJ looked beyond the undisputed program violations to Dr. Evans' and Dr. Orr's testimony – rather than the absence of supporting documentation submitted by Petitioner – in determining whether dysfunctional conditions existed.[28] Although Dr. Orr only found dysfunction in seven of the 85 patients, the ALJ made a wholesale conclusion that there was no evidence of a fraudulent lack of dysfunction.[29] The ALJ failed to explain how the remaining 78 patients did not raise at least a rational inference that the allegation of conscious indifference to Medicaid policy is true.

Even more troubling, the ALJ went on to speculate that the provider Manual "may deem" a score of 26 to indicate dysfunction.[30] Such speculation is unsupported by any of the record evidence. Furthermore, it essentially absolves the Petitioner of any responsibility to demonstrate dysfunction within the clinical record. The ALJ's conclusion was an improper application of the law to the record evidence and an improper interpretation of agency policy.

D. Finding of Fact Number 37.

OIG exeepts to Finding of Fact No. 37 because it does not properly apply or interpret applicable law and rules to the record evidence. Although the opinion acknowledges that TMHP had failed to perform its proper prior authorization functions,[31] the ALJ based *all* faetual conelusions upon the testimony of the very person who had once presided over the broken prior

[27] Exhibit R-X: (Pgs. 7, 11, 14-15, and 60-61)
[28] PFD: 28.
[29] PFD: 28-29.
[30] PFD: 29.
[31] PFD: 8.

authorization process.[32] The ALJ further found that Dr. Orr's testimony was "persuasively corroborated" – incredibly by witnesses with an acknowledged personal financial bias arising out of an incentive to overbill Medicaid.[33] In so doing, the ALJ ignored the testimony of the two disinterested agency witnesses charged with the administration of the Medicaid program who testified about the prior authorization process as it should work and their interpretation of Medicaid policy. An agency must genuinely engage in reasoned decision-making. *Dutchmen*, slip op. at 7; *Waco v. TCEQ*, 346 S.W.3d 781, 819-20 (Tex. App. – Austin 2011, pet. denied). It follows that an ALJ must also engage in reasoned decisions. OIG respectfully submits that the ALJ's conclusions are contrary to the great weight and credibility of the record evidence, and that they constitute a misapplication of the law to the facts.

E. Finding of Fact Number 39.

OIG excepts to Finding of Fact No. 39 to the extent it recommends a limit on the payment hold. Upon finding that the agency is entitled to impose and maintain the hold, the analysis should end. There is no statute that enables SOAH to recommend an appropriate sanction. *See* TEX. GOV'T CODE ANN. §2003.042. The recommendation to reduce the payment hold to nine percent does not fall within the statutory definitions of a finding of fact or a conclusion of law. *See* TEX. GOV'T CODE ANN. §2001.058(e).

The outcome in an administrative hearing lies with the final decision maker. *See Brown v. Tex. State Board of Dental Exam'rs*, 281 S.W.3d 692, 697 (Tex. App. – Corpus Christi 2009, pet. denied). "[T]he choice of penalty is vested in the agency, not in the courts." *Sears v. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751 (Tex. App.-Austin 1988, no pet.); *Brown*, 281 S.W.3d at 697. "The mere labeling of a recommended sanction as a conclusion of law or as a

[32] PFD: 26-27.
[33] PFD: 26, 32.

finding of fact does not change the effect of the ALJ's recommendation." *Brown,* 281 S.W.3d at 697.

Moreover, the recommendation is predicated upon the ALJ's rationale that the purpose of the SOAH hearing was to determine "any final resolution of the alleged fraud and overpayment matter."[34] But this is an interlocutory proceeding and the only issue before SOAH was continuation of the payment hold. The final overpayment and fraud determinations have not yet been determined by OIG. Those issues are not yet ripe and they were not before the court. Thus, the ALJ's attempt to quantify the results of an incomplete investigation was premature.

## II. EXCEPTIONS TO THE CONCLUSIONS OF LAW

A Conclusion of Law Number 10.

OIG excepts to Conclusion of Law No. 10 because it found that state failed to prove knowing or intentional fraud, when the minimum standard for proof is conscious indifference. As previously discussed, the rationale failed to take into account two of the four possible mental states sufficient to demonstrate Medicaid fraud. Additionally, OIG incorporates its exceptions to the findings of fact above to the necessary to dispute the factual conclusions that contributed to this conclusion of law. As previously discussed, this conclusion is based upon: 1) a disregard for the only two disinterested witnesses authorized to speak about Medicaid policy, 2) an incomplete excerpt from the applicable policy, 3) an elevated burden of proof imposed against the state, which is greater than prima facie evidence, 4.) an improper shifting of the burden of proof related to the agency's expert witness and the provider's responsibility to demonstrate dysfunction , and 5) a failure to defer to the agency's reasonable interpretations of its poliey and determinations in light of the evidence.

[34] PFD: 4.

## III. PRAYER

Based upon the foregoing, the OIG respectfully requests that SOAH modify the Proposal for Decision in this matter by: 1) deleting or, in the alternative, modifying Findings of Fact Numbers 26, 27, 28, 31, 32, 33, 34, 35, 37, and 39; 2) deleting or modifying Conclusions of Law Number 10; and 3) deleting the recommended percentage of hold.

Respectfully submitted,

John Medloek
State Bar No. 24060274
Associate Counsel
HHSC/Office of Inspeetor General
Sanctions MC-1358
11101 Metric Blvd., Building I
Austin, Texas 78758
512.491.2052 Phone
512.833.6484 Fax

Corrie Alvarado
State Bar No. 24047350
Associate Counsel
HHSC/Office of Inspector General
Sanctions MC-1358
11101 Metric Blvd., Building I,
Austin, Texas 78758
512.491.5606Phone
512.833.6484 Fax

ATTORNEYS FOR
TEXAS HEALTH AND HUMAN
SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

KAREN NELSON
CHIEF COUNSEL

## CERTIFICATE OF SERVICE

By my signature, I certify that I have on this 4th day of September, 2012, served copies of this Notice of Hearing upon the State Office of Administrative Hearings and upon Petitioner, as follows:

*Via Facsimile: (512) 322-2061*
State Office of Administrative Hearings
300 West 15th Street, Room 504
P.O. Box 13025
Austin, TX 78711-3025

*Via Facsimile: (361) 884-7023*
Harlingen Family Dental
C/o J.A. Tony Canales
Canales & Simonson, P.C.
P.O. Box 5624
Corpus Christi, Texas 78465

John Medlock
HHSC-OIG

Corrie Alvarado
HHSC-OIG

**Texas Health and Human Services Commission**
Office of Inspector General
11101 Metric Blvd. Bldg. I
Austin, Texas 78758

# PLEASE DELIVER IMMEDIATELY TO THE FOLLOWING INDIVIDUAL(S) LISTED BELOW:

| | |
|---|---|
| TO: J.A. "TONY" CANALES<br>CANALES & SIMONSON, P.C.<br><br>PHONE: (800) 527-7381<br><br>FAX: (361) 884-7023 | FROM: JOHN MEDLOCK, ASSOCIATE COUNSEL,<br>OFFICE OF INSPECTOR GENERAL<br><br>PHONE: (512) 491-2052<br><br>FAX: (512) 833-6484 |
| DATE: SEPTEMBER 4, 2012 | NUMBER OF PAGES, INCLUDING COVER SHEET:<br>12 |

Re: Cause No. 529-12-3180; Harlingen Family Dentistry v. Texas Health & Human Services Commission

Please find the following 11 pages relating Texas Health and Human Services Commission, Office of Inspector General's Exceptions to Proposal for Decision. This represents fax 1 of 1.