State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

August 15, 2012

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

VIA INTER-AGENCY

RE: **Docket No. 529-12-3180; Harlingen Family Dentistry v. Texas Health and Human Services Commission, Office of Inspector General**

Dear Commissioner Suehs:

Please find enclosed a Proposal for Decision in this case. It contains my 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,

Shannon Kilgore
Administrative Law Judge

SK/ap
Enclosure
xc: John Medlock, Associate Counsel, Texas Health and Human Services Commission, 4900 N. Lamar, 4th Floor, Austin, Texas 78751 - **VIA INTER-AGENCY**
Fairy Davenport-Rutland, Director, Texas Health and Human Services Commission, Appeals Division, 8407 Wall Street, S300 Austin, Texas 78754 - (with 1 CD) – **VIA INTER-AGENCY**
J.A. Tony Canales, Canales & Simonson, P.C., P.O. Box 5624, Corpus Christi, TX 78465 - **VIA REGULAR MAIL**

300 W. 15th Street, Suite 502, Austin, Texas 78701/ P.O. Box 13025, Austin, Texas 78711-3025
512.475.4993 (Main) 512.475.3445 (Docketing) 512.322.2061 (Fax)
www.soah.state.tx.us

SOAH DOCKET NO. 529-12-3180

HARLINGEN FAMILY DENTISTRY, Petitioner	§	BEFORE THE STATE OFFICE
V.	§	OF
TEXAS HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INSPECTOR GENERAL, Respondent	§	ADMINISTRATIVE HEARINGS

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

PROPOSAL FOR DECISION

Harlingen Family Dentistry (HFD) appeals the decision of the staff (Staff) of the Texas Health and Human Services Commission, Office of Inspector General (HHSC-OIG) to place a payment hold of 40 percent on HFD's Medicaid billing. The hold is based primarily on Staff's allegation that HFD submitted information to Medicaid involving fraud or willful misrepresentation in connection with reimbursement for orthodontic services. Staff also asserts, in the alternative, that HFD is subject to a payment hold based on evidence of non-fraudulent billing for services that are not reimbursable. This Proposal for Decision determines that the evidence supports the maintenance of a payment hold against HFD, not for fraud or misrepresentation, but based on billing for unreimbursable services. The ALJ recommends that the payment hold be reduced to 4 percent of HFD's Medicaid billing.

I. PROCEDURAL HISTORY, NOTICE & JURISDICTION

There are no 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 hearing was held April 24-25, 2012, before Administrative Law Judge (ALJ) Shannon Kilgore at the offices of the State Office of Administrative Hearings (SOAH) in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. HFD appeared through its attorneys of record, J.A. Canales and Oscar Garcia. Staff was represented by attorneys John Medlock and Corrie Alvarado. The record was left open until June 18, 2012,

for the parties to file written closing arguments. The ALJ re-opened the record to require additional briefing on a legal issue, and the record finally closed on July 12, 2012.

II. BACKGROUND

HHSC-OIG prosecutes fraud, waste, and abuse associated with the Texas Medicaid program. Texas Medicaid Health Partnership (TMHP) was the contracted Texas Medicaid claims administrator during the times in question in this case.

HFD, which is owned by Juan Villarreal, D.D.S., is a Texas Medicaid Provider, holding Provider No. 0096471.[1] At the times relevant to this case, HFD did a large volume of orthodontia work billed to Medicaid.

Texas Medicaid policy provides that all orthodontic services for which Medicaid coverage is sought must be preauthorized by TMHP.[2] In making preauthorization decisions, TMHP relies in part on a Handicapping Labio-lingual Deviation (HLD) score sheet to determine whether orthodontic services are medically necessary.[3] The HLD score sheet is filled out by the provider and submitted to TMHP with the prior authorization request, along with other materials such as photographs and radiographs. The score sheet assigns a certain number of points for the following observed conditions: cleft palate, severe traumatic deviations, overjet,[4] overbite, mandibular protrusion, open bite, ectopic eruption, anterior crowding, and labio-lingual spread[5] in millimeters (mm).

The annual Texas Medicaid Provider Procedures Manual (Manual) provides guidance to providers about how to score their patients on the HLD sheet. The Manual states that a

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[1] HFD's Medicaid provider enrollment agreement is at Respondent's Ex. R-I (DVD).

[2] Preauthorization is not a guarantee of reimbursement.

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

[4] "Overjet" is the way that the upper teeth protrude forward. Tr. at 211.

[5] The "labio-lingual spread" is the space between the teeth. Tr. at 187.

minimum of 26 points on the HLD index is necessary to qualify for orthodontic care. Of particular importance to this case are the following portions of the Manual's instructions:

> **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.[6]
>
> **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 crowding.
>
> Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case. The case *must* be considered *dysfunctional* and have a minimum of 26 points on the HLD index to qualify for any orthodontic care other than cross-bite correction.
>
> The intent of the program is to provide orthodontic care to clients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily for aesthetics are not within the scope of benefits of this program.[7]

In 2011, Staff conducted a data analysis of paid Medicaid claims in Texas and determined that HFD was one of the top 25 providers in the state related to high utilization of orthodontia billing. Staff opened fraud investigations against those top 25 providers, including HFD.

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[6] The "alveolar ridge" is the horseshoe-shaped ridge in the upper and lower jaw, over which the teeth erupt. Tr. at 179-180. A "high labial cuspid" has been described in the record as a cuspid, or "eye tooth," that "erupts to the cheek side or the lip side of the alveolar ridge," or sometimes to the roof of the mouth, due to crowding, Tr. at 179 (Evans testimony), or as a tooth that erupts in the labial fold or the labial mucosa. Petitioner's Ex. 8 at 5 (Franklin testimony).

[7] Respondent Ex. R-X at 68 (2007 Manual) (emphasis in original). The language of those instructions remained the same in the 2008-2011 Manuals. Respondent Exs. R-Y through R-BB. As to ectopic eruption and anterior crowding, the Manual further says to score the more serious condition. Respondent Ex. R-X at 68 (2007 Manual).

An orthodontist retained by Staff, Charles Evans, D.D.S., reviewed the clinical records of 85 HFD patients for whom Medicaid prior authorization requests were filed with TMHP, preauthorization was granted by TMHP, and reimbursement was paid, during the 2007 to 2011 time period. Dr. Evans concluded that in 84 of the 85 cases, the clinical records did not support the scoring on the HLD score sheets submitted with the preauthorization requests.

As a result, on October 6, 2011, Staff placed a 40 percent payment hold on HFD's Medicaid reimbursement. This was based on an estimate that 40 percent of HFD's total Medicaid billing was for orthodontic (as opposed to other dentistry) services.[8]

On September 28, 2011, Staff referred HFD to the Medicaid Fraud Control Unit of the Office of the Attorney General (MFCU).[9] On March 5, 2012, MFCU certified that HFD (among a number of providers) is still under investigation for fraud.[10]

HFD requested a hearing concerning the 40 percent payment hold.[11] Whether the payment hold must or may be continued pending the state's investigation and any final resolution of the alleged fraud and overpayment matter is the subject of this SOAH proceeding.

III. APPLICABLE LAW

A. Authorization for Payment Holds

Medicaid, as a federal program administered by the states, is governed by a combination of federal and state laws.

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[8] Respondent's Ex. R-B. While the payment hold notice issued by HHSC-OIG stated that the agency was imposing a "*40% payment hold on payments* of all future claims submitted to Texas Medicaid by Harlingen Family Dentistry for reimbursement *relating to orthodontic services*," *id.* (emphasis added), in fact the payment hold covers 40 percent of HFD's total Medicaid reimbursement. Parties Agreed to Stipulations at 2; Respondent's Ex. R-E; Tr. at 77.

[9] Respondent's Ex. R-VV.

[10] Respondent's Ex. R-UU.

[11] Respondent's Ex. R-D.

Three different Texas statutes bear on the issues in this case: Texas Government Code chapter 531 (which governs the HHSC), 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, which mandates a suspension of all Medicaid payments to a provider 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).[12]

The federal regulation goes on to say that, 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. Further, on a quarterly basis, the state must request a certification from the Medicaid fraud control unit that the matter continues to be under investigation, "thus warranting continuation of the suspension."[13]

"Credible allegation of fraud" is defined by federal rule as "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

[12] 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).

[13] 42 C.F.R. § 455.23(d)(3).

reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.[14]

Texas Human Resources Code § 32.0291(b), in effect since 2003, states that, notwithstanding any other law, HHSC 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.[15] Section 32.0291(c) provides that, in a SOAH hearing on a payment hold, HHSC must make a prima facie showing that the evidence relied on in imposing the hold is relevant, credible, and material to the issue of fraud or willful misrepresentation.

HHSC rules authorize the imposition of a payment hold against a provider, prior to the completion of an investigation, based on "prima facie" evidence of fraud or willful misrepresentation or of various other violations, including violations not rising to the level of fraud, such as submitting claims for services that are not reimbursable or failing to comply with the terms of the Medicaid program provider agreement.[16]

B. Definition of Fraud

The elements of fraud are determined by state law. 42 C.F.R. § 455.2. The relevant definition(s) of fraud is that in effect at the time of the submission of the requests for preauthorization at issue in this case.

Chapter 36 of the Texas Human Resources Code specifically governs Medicaid fraud prevention. At all times relevant to this case, § 36.002(1) has provided that it is an unlawful act to knowingly make or cause to be made a false statement or misrepresentation of a material fact

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[14] 42 C.F.R. § 455.2.

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

[16] 1 Tex. Admin. Code §§ 371.1703(b)(3) and (5), 371.1617(a)(1)(A)-(C) and (K), (5)(A) and (G). The state rules expressly cite to Title 42 of the Code of Federal Regulations as a governing authority. 1 Tex. Admin. Code § 371.1605.

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.

Further, at all times relevant to this case, "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."[17]

In addition, at all times relevant to this case, Texas Government Code § 531.1011(1) has defined "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.

IV. EVIDENCE[18]

Staff offered multiple documents and the testimony of the following witnesses:

- Martin Porras, a Medicaid fraud investigator with HHSC-OIG;
- Brian Klozik, another Medicaid fraud investigator with HHSC-OIG; and
- Dr. Evans, Staff's expert witness.

HFD also offered numerous documents, as well as the testimony of the following witnesses:

- C. Van Nguyen, D.D.S., an orthodontist with HFD (by deposition);
- George Franklin, D.D.S., another orthodontist with HFD (by deposition);

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

[18] The record in this case is voluminous. The ALJ only summarizes the evidence most directly relevant to the Findings of Fact and Conclusions of Law in this Proposal for Decision, including some background information.

- Vivian Teegardin, D.D.S., a general dentist who practices orthodontia with HFD (by deposition);
- James Orr, D.D.S., HFD's primary expert witness in this case;
- Juan Villarreal, D.D.S., the owner of HFD;
- Billy Ray Millwee, HHSC's Deputy Executive Commissioner for Health Services Operations, who serves as the state's Medicaid director (by deposition); and
- Linda Altenhoff, D.D.S., a dentist with the Texas Department of State Health Services who serves as a consultant for HHSC on Medicaid dental policy (by deposition).

A. Recent History of Texas Medicaid Orthodontia Prior Authorization Process

In 2007, the Texas Legislature increased Medicaid reimbursement rates for dental services by 50 percent in an attempt to increase access to dental services for children, and utilization increased accordingly.[19] In 2008, HHSC audited TMHP and examined the information dentists were submitting in support of their requests for prior authorization.[20] HHSC's 2008 audit report recommended an increase in review by licensed dental professionals of prior authorization requests for orthodontia services, so that TMPH personnel would not be in the position of relying solely on the total HLD score reported by the provider.[21] Mr. Millwee, the state's present Medicaid director, suggested in his testimony that TMHP had been depending on the score submitted, and perhaps providers had been exploiting the lack of rigorous review of the underlying bases for preauthorization requests.[22] TMHP responded to the audit's recommendation by saying that an increase in the use of dental professionals would require a change in TMHP's contract, which did not occur.[23]

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[19] Petitioner's Ex. 10-A; Petitioner's Ex. 10 at 28-29.

[20] Petitioner's Ex. 1.

[21] Petitioner's Ex. 1.

[22] Petitioner's Ex. 10 at 61.

[23] Petitioner's Ex. 1; Petitioner's Ex. 10 at 49.

Mr. Millwee testified that, when he assumed the role of Medicaid director in 2010, he became concerned about the high level of orthodontia utilization. Then, in 2011, a news station in Dallas ran a series of exposé-style reports about Medicaid billings related to orthodontia services. The news reports prompted further scrutiny of orthodontia utilization, including another audit of TMHP.[24]

Recent changes to the orthodontia preauthorization process have been made. In the fall of 2011, HHSC announced steps intended to "tighten the enforcement of Medicaid dental policies."[25] They included changes of personnel at TMHP (including the addition of dental professional and other staff), a new requirement that full-cast dental molds must be submitted with all requests for preauthorization for braces, and increased oversight of the preauthorization review process.[26] TMHP is no longer as directly involved in prior authorizations because there is a new dental reimbursement model.[27]

Further, the Manual's definition of ectopic eruption was amended, 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.[28]

Dr. Altenhoff, a consultant to HHSC on Medicaid dental policy, testified that this new language was crafted in response to a query from a provider, at a stakeholder meeting, concerning the interpretation of "ectopic eruption." Dr. Altenhoff stated that she worked on the amended

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[24] Petitioner's Ex. 10 at 26-27. The news stories, which were not admitted for their truth, are at Respondent's Exs. R-HH through R-PP. The news reports did not concern HFD specifically.

[25] Petitioner's Ex. 10-A.

[26] Petitioner's Ex. 10-A.

[27] Petitioner's Ex. 10 at 51.

[28] Petitioner's Ex. 10-A.

definition with several other persons and consulted with, among others, the chair of the orthodontic department of the Baylor College of Dentistry in Dallas.[29]

There is an ongoing federal audit of the state program's orthodontia prior authorization process from September 1, 2008, through May 28, 2011, to look at the issue of medical necessity.[30]

B. HFD's Practice

The owner of HFD is Dr. Villarreal, a dentist in practice in Harlingen for 29 years. He practiced orthodontia, including Medicaid orthodontia, from 1983 to 2003. Dr. Villarreal served on the Texas State Board of Dental Examiners from 2001 to 2008.

On staff at HFD are 12 dentists, among whom two are orthodontists (Drs. Franklin and Nguyen), one is a general dentist who practices orthodontia (Dr. Teegardin), and three are pediadontists. HFD occupies a facility of 26,000 square feet and employs 150 persons. According to Dr. Villarreal, it is one of the largest dental offices in the country.[31] Annual total Medicaid reimbursement (for all dentistry and orthodontia) is about $5 million, with total reimbursement (Medicaid plus private pay) of about $12 million.[32] Dr. Franklin is paid a salary, while Drs. Teegardin and Nguyen are paid a commission based on a percentage of collections.[33]

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[29] Petitioner's Ex. 11 at 36-38.

[30] Petitioner's Ex. 2; Petitioner's Ex. 10 at 39, 66-67; Petitioner's Ex. 10-A.

[31] Tr. at 456-461.

[32] Tr. at 472.

[33] Tr. at 470-471. *See also* Tr. at 303. Dr. Villareal testified that both models of compensation – salary and commission based on production – have been common in dentistry for years. Tr. at 473. Dr. Villareal also clarified that Dr. Franklin recently resigned because he was upset about the payment hold and decline in Medicaid reimbursement. Tr. at 475.

C. The State's Investigation of HFD

Mr. Klozik of HHSC-OIG testified that the genesis of the investigation of HFD was the Dallas news series. After viewing the news stories, Mr. Klozik decided that the HHSC-OIG should look at orthodontia billings.[34] He generated a report reflecting those Medicaid providers in Texas who were billing the highest amounts for diagnoses, braces, and retainers, as well as for special orthodontic appliances.[35] HFD was one of the top-billing providers. Staff opened investigative cases against all 25 top-billing providers.[36]

Mr. Klozik indicated that high utilization of any type of procedure codes can be indicative of fraud, waste, and abuse.[37] He also knew that there were issues generally concerning HLD score sheets.[38] Mr. Klozik stated that he had questioned at some point in the past whether TMHP's review of prior authorization requests was comprehensive. His questioning was based in part on the 2008 HHSC-OIG audit of TMHP's prior authorization reviews for orthodontia services.[39] Mr. Klozik stated, "And so because having that type of knowledge, when you see high utilization, someone like me has to question whether or not providers might be exploiting a process at TMHP that's not very robust or thorough in order to get prior authorization approved for payment."[40]

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[34] Tr. at 126-127, 154, 160-161.

[35] Tr. at 128-130; Respondent's Ex. R-WW.

[36] Tr. 130-131. On cross-examination, Mr. Klozik said that being a top biller is a "red flag," but acknowledged that someone has to be at the top, and admitted that whoever was in the top 20 or 30 providers was subjected to an investigation. Tr. at 147.

[37] Tr. at 130.

[38] Tr. at 161.

[39] Tr. at 133-134.

[40] Tr. at 134-135.

According to Mr. Klozik, he had no evidence, other than the billing numbers, of wrongdoing on the part of HFD when the investigation was opened.[41] He testified that not all 25 top billers received payment holds, but he is unsure how many did.[42]

Mr. Porras of HHSC-OIG testified that, once assigned to investigate HFD, he collected 161 patient records, relating to the 2007 to 2011 time period, and passed them on to Dr. Evans, Staff's expert, for review.[43] Dr. Evans scored 85 of the patients and concluded that, in 84 of those cases, the patients did not meet the threshold of 26 points on the HLD score sheet. At this point, Mr. Porras "determined that this was a credible allegation of fraud."[44] Based entirely on Dr. Evans' evaluation, Mr. Porras recommended that a vendor payment hold be implemented.[45] Mr. Porras did not discuss the scoring with the HFD providers who had filled out the original sheets and submitted them for prior authorization.[46] Mr. Medlock, the attorney for HHSC-OIG, made the decision to implement the payment hold, which went into effect in October 2011.[47] The matter was also referred to the MFCU for investigation. According to Mr. Porras, the MFCU generally accepts such referrals.[48] He is unaware what, if anything, has been done in the case by the MFCU.[49]

D. The HLD Score Sheets at Issue

The crux of the dispute is the appropriateness of the HLD scoring performed by HFD's orthodontic providers. The score sheets for the 85 patients at issue were filled out by the HFD

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[41] Tr. at 141-142.

[42] Tr. at 143.

[43] Tr. at 71-75.

[44] Tr. at 75.

[45] Tr. at 76, 90-91, 123. Mr. Klozik agreed that Dr. Evans' report was the pivotal point in determining that there was a credible allegation of fraud warranting a payment hold. Tr. at 144.

[46] Tr. at 98-99.

[47] Tr. at 98.

[48] Tr. at 79.

[49] Tr. at 105, 110, 113.

orthodontists, Drs. Nguyen, Franklin, and Teegardin. In each case, the HFD provider scored the patient at 26 (the minimum score for Medicaid qualification) or more points.

As noted above, Dr. Evans, Staff's expert witness, reviewed the 85 patients' records (including in most cases photographs, x-rays, treatment notes, and molds) and filled out his own HLD score sheet for each patient. His scores were much lower than those of the HFD providers; in 84 cases, his scores failed to reach the threshold of 26 points for Medicaid coverage. Dr. Orr, HFD's expert witness, also reviewed the 85 patients' records and filled out a score sheet for each. His scores tended to be significantly higher than those of Dr. Evans, with most of his scores exceeding 26 points.[50] In most cases, the three scorers – the provider, Dr. Evans, and Dr. Orr – arrived at three different totals.

A summary of the scores for each patient is presented in Appendix 2.

The scores calculated by the HFD providers and Dr. Orr tend to include large numbers of points for ectopic eruption. On the score sheet, each tooth considered to involve ectopic eruption is given 3 points. For example, Dr. Evans scored patient G (No. 82 on the chart below) as having 2 teeth exhibiting ectopic eruption, for 6 points, and included an additional 5 points for anterior crowding, for a total of 11 points – well below the 26-point threshold.[51] Dr. Orr considered the same patient to have 12 teeth exhibiting ectopic eruption, for a total of 36 points – well above the 26-point threshold.[52] Dr. Teegardin considered 10 teeth to be examples of ectopic eruption, for a total of 30 points.[53] This pattern of widely varying scores for ectopic eruption can be seen in the vast majority of the 85 patients. Indeed, Dr. Evans identified HFD's scoring of ectopic eruption as the only significant disagreement he had with the HFD providers'

[50] Dr. Orr did not score several patients due to an insufficiency in the records provided to him.

[51] Respondent's Ex. R-R at 82.

[52] Respondent's Ex. R-SS at 86.

[53] Respondent's Ex. R-T82.

calculations.[54] The definition and interpretation of "ectopic eruption" therefore lie at the heart of this case.

As set out in section II above, the Manual defines 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 Manual further states that eligibility requires dysfunction, with the intent of the program being to provide orthodontic care to clients with handicapping malocclusion.

E. Expert Dental Testimony

1. Dr. Evans

Dr. Evans graduated from the University of Texas' dental branch in Houston in 1967. From 1967 to 1971, he completed an orthodontic residency in Kansas. He then came to Austin, where he has practiced orthodontia for over 40 years. He has treated approximately 15,000 patients. While not a board-certified orthodontist, he is certified in orthodontics by the Southwestern Society of Orthodontics and the American Association of Orthodontists.[55] He has never practiced Medicaid orthodontia and had no professional familiarity with the HLD score sheet prior to working as a consultant to Staff in this case.[56]

Staff instructed Dr. Evans to be lenient in his scoring of borderline cases and give credence to the scoring done by the provider in such instances.[57] Dr. Evans stated that he relied on the score sheet itself and the instructions in the Manual for guidance about how to score patients. He noted that the Manual requires 26 points as well as a handicapping malocclusion for

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[54] Tr. at 210, 214, 238-239.

[55] Tr. at 169-170, 217, 267.

[56] Tr. at 212, 214, 259. He testified that he had some experience with a similar form, for another insurer, in the 1970s. Tr. at 217-225.

[57] Tr. at 172.

eligibility for reimbursement. According to Dr. Evans, a handicapping malocclusion is some impairment in functions like eating or speech.[58]

Dr. Evans described teeth that are "grossly out of the long axis of the alveolar ridge" as follows:

> Well, by being grossly out of the ridge we're not talking about just a minor difference. I mean, the tooth can come in and be just a little bit crowded to the outside or the inside. But still in a normal position. Certainly not a tooth that would be rotated or turned you wouldn't consider that being off of the ridge. It's on the ridge, but maybe turned a little bit. To be grossly out of the ridge would be if it's really coming in up high and way out of position like a labial cuspid or maybe under the roof of the mouth, I've seen a lot of those teeth. Particularly the cuspids that are actually growing horizontally. Some are even inverted going up. I mean, that is – that's grossly off the alveolar ridge.[59]

Dr. Evans criticized the HFD providers' characterization of teeth as ectopic if the teeth were arguably on the alveolar ridge.[60]

Dr. Evans testified specifically as to several of the patient files he reviewed. As to patient No. 40, who was scored by HFD at 26 points but by Dr. Evans at 1 point, Dr. Evans testified that there was "no way" that 8 of the patient's teeth were off the alveolar ridge as, Dr. Evans said, the HFD score sheet indicates.[61] When asked if the patient might have had a functionality problem, Dr. Evans stated, "Absolutely not. If this patient has a handicapping occlusion everybody in this room does, too."[62] Further, as to patients Nos. 47, 52, 58, 77, and 81, Dr. Evans disagreed with

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[58] Tr. at 177, 185.

[59] Tr. at 181.

[60] Tr. at 190-191, 207-208.

[61] Tr. at 189-190. The ALJ notes that the score sheet scores 8 teeth under the category under ectopic eruption, but the score sheet does not state that the teeth are off of the alveolar ridge. Ex. R-T40.

[62] Tr. at 191.

the number of teeth scored by HFD providers as ectopic.[63] As to patients Nos. 52, 58, and 81, he testified that there was no handicapping malocclusion.[64]

At hearing, Dr. Evans acknowledged that he had mistakenly scored several patients too highly, in that he counted both ectopic eruption and anterior crowding in a manner prohibited by the Manual. Even with his mistaken overscoring, his total calculation in each of those cases failed to meet the 26-point threshold. When asked about his mistakes, he explained in part, "This is the first time I've completed those sheets."[65]

As to the definition of ectopic eruption, Dr. Evans testified that he sought definitions in orthodontic textbooks and found none. Therefore, he relied exclusively on the Manual's instructions in determining which teeth were ectopic and which were not for purposes of the HLD score sheets.[66] Dr. Evans stated that he reads the Manual as offering a slightly subjective definition of ectopic eruption – "an unusual pattern of eruption" – followed by two non-exclusive examples, "high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge."[67] Due to the very large discrepancy between his scores and those of the HFD providers, Dr. Evans stated that he does not see how they could have been relying on the instructions in the Manual.[68]

While Dr. Evans' interpretation of ectopic eruption and scoring of the patients differed from those of HFD providers, Dr. Evans had no opinion about whether HFD was engaged in fraud or willful misrepresentation.[69]

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[63] Tr. at 192-200, 204-208. His discussion of patient No. 56 indicated that the patient needed treatment, but still might not be eligible for Medicaid coverage. *Id.* at 200-204.

[64] Tr. at 194, 197, 200.

[65] Tr. at 208, 213-214, 259.

[66] Tr. at 241.

[67] Tr. at 250-252.

[68] Tr. at 263.

[69] Tr. at 239-240.

2. Dr. Orr

Dr. Orr is a dentist who, by virtue of having completed a two-year residency and then a further two years of post-graduate study, is a specialist in "occlusion," which he described as the way that the teeth contact each other, both sideways and up and down. He testified that an occlusion specialist "tells the orthodontist where to put the teeth."[70] He has never practiced orthodontia.[71]

Dr. Orr is the former Texas Medicaid dental director, having been employed by National Heritage Insurance Corporation (NHIC), the Texas Medicaid contractor prior to TMHP, from 1995 through 2003. In that capacity, Dr. Orr personally approved or disapproved every orthodontic Medicaid prior authorization request submitted. He stated that he also often consulted with the providers concerning their requests.[72]

Dr. Orr testified that, during his nine years as the Medicaid dental director for Texas, the definition of ectopic eruption and the 26-point threshold were the same as they were at the time HFD submitted the claims for reimbursement at issue in this case.[73] During his time at NHIC, Dr. Orr said, he would review difficult cases, which usually involved questions about ectopic eruption, with a retired orthodontist.[74]

Dr. Orr stated that he is not aware of any bulletin or policy statement issued by the state concerning the definition of ectopic eruption, other than that in the Manual.[75] According to Dr. Orr, most of the conditions included as part of the point system on the HLD score sheet – cleft palate, severe traumatic deviations, overjet in millimeters, overbite in millimeters, mandibular protrusion in millimeters, and open bite in millimeters – are objectively observable

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[70] Tr. at 370.

[71] Tr. at 368-369.

[72] Tr. at 376-377.

[73] Tr. at 379, 381.

[74] Tr. at 425-426.

[75] Tr. at 382.

or measurable. In contrast, he stated, diagnosing ectopic eruption involves subjective judgment.[76]

Dr. Orr believes that the actual definition of ectopic eruption in the Manual is the first five words: an unusual pattern of eruption. He stated that the words that follow, "such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge," are examples only. There are, he indicated, hundreds of ways in which bone and teeth could display irregularities that would meet the definition. Dr. Orr opined that Dr. Evans, in reaching his much lower scores, must have considered those examples as further definitional language. Dr. Orr stated, "[S]omebody has chosen to only utilize the two examples of ectopic eruption rather than the decades old rule that frankly everyone in the world uses."[77] Dr. Orr agreed that the Manual requires both 26 points and dysfunction for Medicaid reimbursement.[78]

Like Dr. Evans, Dr. Orr testified specifically about a number of the patients whose files he reviewed. He stated that he scored patient No. 7 as "28 to infinite" because there were teeth that were beyond measurement.[79] With respect to patient No. 19, Dr. Orr scored the child at 36 points because all 12 anterior teeth were very far off of the supporting bone, noting that it would take a "heroic clinical effort" to treat the patient.[80] He also stated that, if patients like No. 19 are treated, they would not have "social and psychological problems," although Dr. Orr denied that he considered cosmetic or aesthetic issues when scoring patients.[81] With respect to patient No. 33, Dr. Orr testified that he had an open bite in which the teeth do not engage properly, and this condition is dysfunctional.[82] Likewise, he stated, patient No. 34 had lower front teeth off the bone, twisted and rotated completely out of position, with an incompetent bite

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[76] Tr. at 383-385.

[77] Tr. at 382, 385, 394. The ALJ notes that Dr. Evans stated he considered the examples as non-exclusive illustrations. Tr. at 250-252.

[78] Tr. at 435.

[79] Tr. at 388. The ALJ is unsure what Dr. Orr meant by his statement.

[80] Tr. at 401.

[81] Tr. at 401, 442.

[82] Tr. at 404.

that could create chewing dysfunction.[83] Dr. Orr also testified that patient No. 67 had 12 teeth "dramatically" off the alveolar ridge.[84] He said that patient No. 48 qualified for Medicaid, and he further testified about patients Nos. 23, 45, 53, and 85, saying that they all met reimbursement thresholds and all likely had dysfunctional malocclusion.[85]

On cross-examination, Dr. Orr admitted that he mistakenly scored both ectopic eruption and anterior crowding for patient No. 40, resulting in an incorrectly high score (31 as opposed to 26). As to the same patient, Dr. Orr stated that the dysfunctional bite could be observed in the abnormal wear on the front teeth, which were already 8-10 percent shorter, and that the patient's malocclusion probably contributed to difficulty chewing.[86]

3. Dr. Nguyen

Dr. Nguyen obtained a B.S. and an M.S. in engineering from the University of Tennessee, then graduated from the UCLA dental school, and then completed a residency in orthodontics at Temple University in Philadelphia in 2002. He has been board-certified in orthodontia since 2007. After practicing orthodontia in Dallas, Dr. Nguyen moved to Harlingen 3 years ago to practice at HFD. Prior to working at HFD, Dr. Nguyen had not treated Medicaid patients. Dr. Nguyen reports to Drs. Teegardin and Villarreal.[87]

As to the patients Dr. Nguyen scored for prior authorization purposes and who are at issue in this case, he testified that his scoring was based solely on his independent dental judgment. He stated he had no intent to commit fraud or misrepresentation.[88]

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[83] Tr. at 406-407.

[84] Tr. at 394.

[85] Tr. at 395-416.

[86] Tr. at 451-453.

[87] Petitioner's Ex. 9 at 2-4.

[88] Petitioner's Ex. 9 at 9-12.

4. Dr. Franklin

Dr. Franklin went to dental school and did two further years of orthodontic training at Howard University in Washington, D.C. He has been an orthodontist for 30 years and has practiced with HFD for over 4 years. [89]

Dr. Franklin testified that overjet, overbite, mandibular protrusion, and open bite are all measurable conditions, but ectopic eruption is a subjective component in HLD scoring.[90] He stated that a score of 26 or more points on the HLD score sheet indicates that the patient has severe malocclusion and that treatment is medically necessary.[91] As to all of the patients he scored and who are at issue in this case, Dr. Franklin testified that he based his scoring on the Manual's instructions, his clinical exam, and his professional judgment. He testified that there was no fraud or misrepresentation. He believes he scored the patients fairly.[92]

On cross-examination, Dr. Franklin stated that patient No. 50 likely had no problems chewing food and patient No. 72 had no functionality problem.[93] He acknowledged that for each of 16 out of 20 patients he scored, nine teeth were counted as ectopic.[94]

5. Dr. Teegardin

Dr. Teegardin graduated from Pan American University in Edinburg in 1985, and from dental school at the University of Texas Health Science Center in San Antonio in 1989. She has practiced as a general dentist for 23 years. She has practiced orthodontia, including Medicaid

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[89] Petitioner's Ex. 8 at 2-3.

[90] Petitioner's Ex. 8 at 6.

[91] Petitioner's Ex. 8 at 6-7.

[92] Petitioner's Ex. 8 at 9-10.

[93] Tr. at 325-326. His testimony as to a third patient is unclear, because the question could have been interpreted to be asking about the patient's post-treatment condition. Tr. at 325.

[94] Tr. at 326.

orthodontia, since about 1989, but her practice has consisted primarily of orthodontia since 2004. She trained to use the HLD score sheet under Dr. Villarreal.[95]

Dr. Teegardin testified that she fills out HLD score sheets alone in her office with the patient's records, which include her chart notes from the physical examination. She moves down the score sheet, item by item.[96] She stated that the HLD scoring process and instructions have not changed over the 23 years of her practice, except for the recent amendment to the definition of ectopic eruption; the way she scored patients in 1990 was the same as the way she scored patients in 2010.[97] Her focus was always on the language, "an unusual pattern of eruption."[98] According to Dr. Teegardin, the determination whether teeth exhibit an "unusual pattern of eruption" is "subjective completely" and involves the exercise of professional judgment.[99] She stated that all of her HLD score sheets at issue represent patients for whom treatment was medically necessary and who had severe handicapping malocclusion, and that she committed no fraud.[100]

6. Dr. Villarreal

Dr. Villarreal testified that the definition of ectopic eruption is a subjective matter. He said that, when Dr. Orr was with NHIC, they would discuss close cases and so, as to the interpretation of the definition of ectopic eruption, Dr. Villarreal said, "I knew where I stood."[101] He stated that he had looked at some of the cases at issue, and he disagreed with his staff providers as to some of the patients, but that often a conversation with the provider would enable

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[95] Petitioner's Ex. 7 at 2-4.

[96] Petitioner's Ex. 7 at 3, 7-8.

[97] Petitioner's Ex. 7 at 5.

[98] Petitioner's Ex. 7 at 12.

[99] Petitioner's Ex. 7 at 6, 7.

[100] Petitioner's Ex. 7 at 11-12.

[101] Tr. at 462-463.

him to understand the reasoning behind the scoring. He indicated he would not have anyone working for him who would attempt to commit fraud.[102]

7. Dr. Altenhoff

Dr. Altenhoff indicated in a 2010 e-mail that she did not believe that "grossly out of the long axis" had ever been defined by the Texas Medicaid program.[103] She seemed to indicate in her testimony that the "grossly out of the long axis" language did not represent merely an example of ectopic eruption, and that the definition of ectopic eruption, even in 2010, would not have included a tooth that was only rotated or leaning out of place.[104]

V. ALJ'S ANALYSIS

A. Authority to Impose Payment Hold

HFD argues that HHSC-OIG has no power to impose the payment hold under either Texas statute authorizing payment holds, Texas Human Resources Code § 32.0291(b) or Texas Government Code § 531.102(g)(2). The ALJ is not persuaded by HFD's arguments, and concludes that both statutes (as well as the applicable state and federal rules) are potential sources of authority for the OIG in this matter.

Petitioner first contends that § 32.0291(b) is not applicable to the instant case because the payment hold here was instituted by HHSC-OIG, and § 32.0291(b) applies only to HHSC, not HHSC-OIG. However, it is clear that HHSC-OIG is part of HHSC, and that HHSC can act through the OIG.[105] Therefore, there is no reason to conclude that § 32.0291(b) is not a source of authority for HHSC-OIG.

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[102] Tr. at 264-266.

[103] Petitioner's Ex. 3.

[104] Petitioner's Ex. 11 at 19-20.

[105] *See* Tex. Gov't Code § 531.102 ("The [Texas Health and Human Services Commission], *through the commission's office of inspector general*, is responsible for the investigation of fraud and abuse in the provision of health and human services and the enforcement of state law relating to the provision of those services") (emphasis added). This language was in effect at all times pertinent to this case.

HFD next asserts that, because Texas Government Code § 531.102(g)(2), which mandates that HHSC-OIG impose a payment hold against a provider based on reliable evidence of fraud or willful misrepresentation, became effective after the allegedly fraudulent claims for reimbursement were made, HHSC-OIG lacks authority to impose the payment hold. In particular, HFD contends that Staff's reliance on § 531.102(g)(2) constitutes the impermissible retroactive application of a statute.[106] This argument fails for several reasons. First, the payment hold is not a retroactive law, but is a procedural mechanism by which the state preserves its assets, prospectively, while it carries out an investigation for fraud. While it is based on events in the past, it is imposed due to an ongoing concern about a provider. Further, for a statute to have an unconstitutionally retroactive effect, it must affect a vested right; however, HFD has no property interest in reimbursements withheld pending a fraud investigation.[107]

Further, throughout the period of concern in this case – from 2007 to the present – there has been authorization for the state to impose a payment hold on providers under investigation for fraud and other violations. Texas Human Resources Code § 32.0291, discussed above, which provides that HHSC may impose a payment hold if there is reliable evidence of fraud or willful misrepresentation, has been in effect since 2003. And HHSC's Rule 371.1703(b), providing for payment holds prior to the completion of an investigation, based on "prima facie" evidence of fraud or willful misrepresentation and for other violations, was promulgated in its present form in 2005.

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[106] No bill of attainder, ex post facto law, retroactive law, or any law impairing the obligation of contracts, shall be made. Tex. Const. art. I, § 16.

[107] *Liberty Mutual v. TDI*, 187 S.W.3d 808, 820 (Tex. App.—Austin 2006, pet. denied) (a retroactive law violates the Texas Constitution when the law deprives parties of a vested right); *Personal Care Products v. Hawkins*, 635 F.3d 155, 159 (5th Cir. 2011), cert. denied, 132 S. Ct. 111 (2011) (provider lacks a protected property interest in reimbursements withheld pending a fraud investigation). In addition, HFD's Medicaid provider agreement, signed in 1999, states, "Provider agrees to comply with all of the requirements of the provider manual as well as all state and federal laws and *amendments* governing or regulating Medicaid." Tr. at 69-70, 84 (referring to and quoting Respondent's Ex. R-I) (emphasis added).

B. Applicable Standard of Proof

The standard of proof required for a payment hold is governed by two applicable state statutes, federal rules, and a state rule. The language of these several sources of law contains assorted similar words to describe the information on which a payment hold must be based. They provide that HHSC must have:

- *reliable evidence* that the circumstances giving rise to the payment hold involve *fraud or willful misrepresentation* (Tex. Gov't Code § 531.102(g)(2));
- a *credible allegation* of *fraud* (42 C.F.R. § 455.23), and allegations are credible when *verified* or when they have *indicia of reliability* and the state has *reviewed all allegations, facts, and evidence carefully and acts judiciously* (42 C.F.R. § 455.2);
- *prima facie evidence* that is *relevant, credible, and material* to *fraud or willful misrepresentation* (Tex. Hum. Res. Code § 32.091(c)); or
- *prima facie evidence* of *fraud or willful misrepresentation* or *other violations, such as submitting claims for services that are not reimbursable or not in compliance with the Manual* (1 Tex. Admin. Code §§ 371.1703(b)(3) and (5), 371.1617(a)(1)(A)-(C), (K) and (5)(A), (5)(G)).[108]

Under this varying but similar language, Staff has the burden to make an evidentiary showing in support of the payment hold. The burden is clearly less than a preponderance of the evidence. Indeed, these statutes and rules contemplate that a payment hold is a measure put into place while an investigation pends, before any final determination of fraud or other violation has been reached. Nonetheless, the evidence supporting the payment hold must be reliable or verifying, have indicia of reliability, or be credible. The federal rule makes clear that the credibility of the allegations must be judged in light of a careful review of all the allegations, facts, and evidence.

[108] All emphasis added.

C. Evidence of Fraud or Willful Misrepresentation

1. HLD Scoring

Staff relies on the testimony of Dr. Evans in support of its imposition of a payment hold on the basis of fraud. Both Messrs. Porras and Klozik indicated that Dr. Evans' review was the pivotal point in determining there was a credible allegation of fraud warranting a payment hold. Other "evidence" of fraud is negligible at best. That HFD was a large and growing Medicaid utilizer is not, by itself, evidence of fraud. Nor does the fact that two providers at HFD were paid on commission constitute evidence of fraud. Nor is it evidence of fraud that Dr. Villarreal sometimes told aggressive parents that he was unsure whether preauthorization requests for orthodontia for their children would be approved.[109] Dr. Evans testified that, in 84 of 85 cases he reviewed, HFD submitted requests for preauthorization for services not reimbursable under Medicaid. If, indeed, 99 percent of the sample cases reviewed were ineligible for Medicaid coverage, this could be circumstantial evidence of fraud. Dr. Evans' testimony is essential to Staff's fraud case. The first question, therefore, is whether Dr. Evans' testimony is reliable or verifying, has indicia of reliability, or is credible, in light of a careful review of all the facts and evidence.

Dr. Evans has been a treating orthodontist for over 40 years, and his patients have numbered in the tens of thousands. His general expertise as an orthodontist is beyond doubt. However, in the unusual context of this case, his testimony about HLD scoring is not enough to support a finding that there is a credible allegation of fraud against HFD. The chief dispute between the parties is what constitutes "ectopic eruption," a term on the HLD score sheet used in Medicaid orthodontia cases.

Dr. Evans testified that he has treated no Medicaid patients and had no familiarity with the HLD score sheet prior to his work in this case. Dr. Evans' lack of Medicaid experience would be no detriment under either of two circumstances: first, if the existence of ectopic

[109] Tr. at 463-464. The cases might have been borderline cases.

eruption were subject to objective verification, or, second, if the term had widespread currency and accepted meaning in orthodontics outside the Medicaid context. However, the Manual's definition of ectopic eruption – "an unusual pattern of eruption"[110] – is extremely vague, and its use unquestionably requires the exercise of subjective judgment. Further, Dr. Evans testified that the first thing he did when he was hired as a consultant in this case was to go to the library and look in orthodontia texts for definitions of the term. He found none. There is nothing in the record in this case from (or referring to) scholarly writings or standard orthodontic reference materials shedding light on the meaning of "ectopic eruption" or suggesting that there is a widespread, non-Medicaid understanding of the specifics of the term's meaning among orthodontia providers. In interpreting this imprecisely defined term, which seems to have little common understanding or use outside of Medicaid, the usual interpretation (especially by the state) of the term in the Medicaid context is relevant and important.[111] Dr. Evans has no specialized knowledge whatsoever to offer in that regard. His lack of Medicaid expertise, by itself, therefore, seriously calls into question the reliability and credibility of his testimony about the scoring of the patients at issue.

The ALJ must further consider Dr. Evans' testimony in light of the other evidence in the record. In contrast with Dr. Evans, Dr. Orr has considerable relevant expertise. First, his specialty is occlusion, and malocclusion is precisely the condition addressed by Medicaid orthodontia. That Dr. Orr is not a specialist in the mechanics of treating malocclusion is beside the point; he is an expert concerning whether teeth are positioned to ensure a proper bite, and the pre-treatment condition of the patients is the concern in this case. Moreover, Dr. Orr's 9 years of experience as the director of the Texas Medicaid dental program, in which capacity he routinely interpreted the term "ectopic eruption" on behalf of the state, makes him very qualified to opine about the term's meaning. And, his testimony indicating that the term has, for decades in the Texas Medicaid program, had a more expansive meaning that the one employed by Dr. Evans was persuasively corroborated by Drs. Teegardin and Villarreal, who both stated that they had

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[110] Both Dr. Evans and Dr. Orr agreed that the further language in the Manual's definition – "such as high labial cuspids and teeth that are grossly out of the long axis of the alveolar ridge" – sets forth nonexclusive illustrations only.

[111] This is especially true, given the "knowing" or "intentional" requirements in the applicable definitions of fraud.

been consistently interpreting the term for decades in a manner that resulted in approval and reimbursement by the state. This evidence was uncontroverted.

Finally, the recent change in the Manual's definition of ectopic eruption significantly undermines Dr. Evans' apparent view that the term, before the 2012 change, did not include teeth that were on or near the alveolar ridge but otherwise out of position. Although he claimed that he regarded the language about high labial cuspids and teeth grossly off the alveolar ridge as examples only, Dr. Evans nonetheless criticized the HFD providers' characterization of teeth as ectopic if the teeth were arguably on the ridge. But only after the submission of the requests for preauthorization in this case was the Manual amended to say that 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.

In sum, the record indicates that Dr. Evans' view of ectopic eruption and his scoring of the patients at issue – on which the state's allegations of fraud and misrepresentation primarily rest – are not credible, reliable, or verifying, and lack indicia of reliability.

Although Dr. Evans' testimony about HLD scoring is insufficient to support the payment hold, the fact remains that even Dr. Orr arrived at a score of less than 26 in 8 of the reviewed 85 cases (patients Nos. 12, 14, 35, 43, 52, 71, 81, and 83). Therefore, under Dr. Orr's assessment, approximately 9 percent of the reviewed cases did not meet the threshold for reimbursement. With both Dr. Evans and Dr. Orr essentially agreeing as to that approximately 9 percent, the ALJ concludes there is reliable, prima facie evidence that those patients were not eligible for Medicaid coverage.

The question then becomes whether submission of requests for prior authorization, 9 percent of which were for ineligible patients, constitutes circumstantial evidence that fraud or misrepresentation occurred. The ALJ concludes that it does not. In the context of scoring that involves the exercise of professional judgment, and a prior authorization system that contemplates denial of some requests, a level of only 91 percent eligibility is not by itself

suggestive of knowing or intentional fraud or misrepresentation. Whether the 9 percent ineligibility supports a payment hold for other, non-fraudulent violations is a different question, and is discussed below under section V.D. ("Prima Facie Evidence of Other, Non-Fraudulent Violations").

2. Handicap or Dysfunction

The Manual makes clear that dysfunction, and not just a cosmetic problem, is a prerequisite to coverage. According to the Manual, the intent of the Medicaid orthodontia program is to provide orthodontic care to clients with handicapping malocclusion. HHSC-OIG argues that the reviewed patients lacked dysfunctional conditions, and HFD's requests for prior authorization for the patients were fraudulent.

Dr. Evans testified that, as to four patients (Nos. 40, 52, 58, and 81), there was no handicapping malocclusion. He also made a general statement in his report that he did not observe any "extenuating circumstances that I felt would be considered handicapping."[112] On the other hand, Dr. Orr testified that seven patients (Nos. 23, 33, 34, 40, 45, 53, and 85) likely had dysfunctional malocclusion.

This is a difficult issue to analyze. There is some evidence about a lack of dysfunction, but it is limited to Dr. Evans' specific testimony about only four patients,[113] plus his one general statement in his report. The focus of the evidence in this case was on the HLD scoring, and comparatively little direct attention was paid to any separate question of dysfunction. Further, Dr. Orr's specific testimony about several patients' malocclusion is especially compelling, given that Dr. Orr is an occlusion specialist. For example, as to patient No. 40, Dr. Evans stated, "If this patient has a handicapping occlusion everybody in this room does, too." However, Dr. Orr pointed to specific evidence that he believed indicated actual dysfunction in the same patient: the measurable wearing down of the front teeth.

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[112] Ex. R-O.

[113] Two of these patients, Nos. 52 and 81, are also patients found by Dr. Orr not to qualify.

Moreover, the requirements of the Manual concerning handicapping malocclusion are somewhat puzzling and ambiguous. While the Manual states that both a score of 26 and dysfunction are necessary, the scoring is entitled "*Handicapping* Labio-lingual Deviation,"[114] thereby strongly suggesting a presumptive correlation between the HLD score and the level of dysfunction.[115] In fact, the Manual also says, "Orthodontic services include the following: Correction of severe handicapping malocclusion *as measured on the handicapping labial lingual deviation index*."[116] Therefore, it appears that the Manual may deem a score of 26 to indicate the presence of a handicapping malocclusion, and the requirement of dysfunction may not necessitate any separate showing.

On the basis of this record, the ALJ cannot conclude that there is evidence that is credible, reliable, or verifying, or has indicia of reliability, that a fraudulent lack of dysfunction existed among the 85 patients.

3. Investigation by MFCU

Staff's Third Amended Complaint asserts that the acceptance of a fraud investigation referral by the MFCU, and the MFCU's subsequent certification that HFD is still under investigation for fraud, together constitute a credible allegation of fraud.[117] The ALJ disagrees. While the federal rule at 42 C.F.R § 455.23 indicates that acceptance of a referral and certification that an investigation is ongoing are reasons to *continue* a payment hold, there is nothing in the language of the rule or in the definition of "credible allegation of fraud"[118] to suggest that the mere pendency of a MFCU investigation is enough to support the imposition of a payment hold. Indeed, the federal rule clearly contemplates that the state Medicaid agency will

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[114] Emphasis added.

[115] Dr. Franklin testified that, as to two of his approximately 25 patients at issue, he did not think that they had problems chewing food, although he also testified that an HLD score of 26 or more meant that the patient had severe malocclusion warranting treatment.

[116] Ex. R-X at 61 (emphasis added).

[117] The ALJ, in a telephonic prehearing conference held on April 20, 2012, overruled HFD's objections to the addition of this alleged basis for a payment hold to HHSC-OIG's Third Amended Complaint. To the degree that HFD's post-hearing arguments re-urge its objections, they are again overruled.

[118] 42 C.F.R. § 455.2.

first determine the existence of the credible allegation, then impose the payment hold and refer the matter to the MFCU.[119] The credible allegation therefore supports, rather than is defined by, the MFCU referral. Staff must provide evidence, separate and apart from the referral and pendency of the MFCU investigation, of a credible allegation of fraud.

D. Prima Facie Evidence of Other, Non-Fraudulent Violations

HHSC's rule broadly authorizes the OIG to impose a payment hold on payments of future claims submitted for reimbursement after it is determined that prima facie evidence exists of any of various non-fraudulent violations.[120] Those violations include:

- billing or causing claims to be submitted to the Medicaid or other HHS program for services or items that are not reimbursable by the Medicaid or other HHS program (1 Tex. Admin. Code § 371.1617(1)(K));
- failing to comply with the terms of the Medicaid or other HHS program contract or provider agreement, assignment agreement, the provider certification on the Medicaid or other HHS program claim form, or rules or regulations published by the Commission or a Medicaid or other HHS operating agency (1 Tex. Admin. Code § 371.1617(5)(A)); and
- failing to comply with Medicaid or other HHS program policies, published Medicaid or other HHS program bulletins, policy notification letters, provider policy or procedure manuals, contracts, statutes, rules, regulations, or interpretation previously sent to the provider by an operating agency or the commission regarding any of the authorities listed above, including statutes or standards governing occupations (1 Tex. Admin. Code § 371.1617(5)(G)).

As discussed above, evidence indicates that approximately 9 percent of the patients at issue (for whom requests for preauthorization were made and approved, and claims for reimbursement were submitted and paid) were not eligible for Medicaid coverage. There is prima facie evidence that, as to these patients, HFD billed Medicaid for unreimbursable services

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[119] 42 C.F.R. § 455.23(a) ("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....") (emphasis added); 42 C.F.R. § 455.23(d) (whenever a State Medicaid agency investigation leads to the initiation of a payment suspension, the agency must make a fraud referral to the MFCU).

[120] 1 Tex. Admin. Code § 371.1703(b)(5).

and failed to follow the instructions in the Manual as to determining who was eligible for coverage. HFD's provider agreement requires it to follow the Manual.[121] Therefore, the OIG has authority to maintain a payment hold against HFD under these state regulations.[122]

E. Conclusion and Recommendation

Staff has not made a sufficient showing to support a payment hold against HFD based on suspected fraud or misrepresentation. However, HHSC-OIG has authority to maintain a payment hold based on prima facie evidence of other violations.

Nothing in the HHSC's rule mandates that a payment hold necessarily be a 100 percent hold on all future claims. The hold in place is a 40 percent hold because it is estimated that about 40 percent of HFD's Medicaid work is related to orthodontic care. It would be reasonable for any continued payment hold to be proportional to the magnitude of the problem indicated by the reliable evidence. Therefore, the ALJ recommends that the payment hold be reduced to 9 percent of the 40 percent of HFD's total Medicaid reimbursement that is related to orthodontics, or 4 percent of HFD's total Medicaid reimbursement.

VI. FINDINGS OF FACT

1. Harlingen Family Dentistry (HFD) is a dental clinic in Harlingen, Texas, owned by Juan Villarreal, D.D.S.

2. HFD is a Texas Medicaid Provider, holding Provider No. 0096471. At the times relevant to this case, HFD did a large volume of orthodontia work billed to Medicaid.

3. On staff at HFD are 12 dentists, among whom two are orthodontists (Drs. George Franklin and C. Van Nguyen), one is a general dentist who practices orthodontia (Dr. Vivian Teegardin), and three are pediadontists.

4. HFD occupies a facility of 26,000 square feet and employs 150 persons.

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[121] Tr. at 69-70.

[122] 1 Tex. Admin. Code § 371.1703(b)(5); 1 Tex. Admin. Code § 371.1617(1)(K), and (5)(A) and (G).

5. HFD's annual total Medicaid reimbursement (for all dentistry and orthodontia) is about $5 million, with total reimbursement (Medicaid plus private pay) of about $12 million. Dr. Franklin is paid a salary, while Drs. Teegardin and Nguyen are paid a commission based on a percentage of collections.

6. Texas Medicaid Health Partnership (TMHP) was the contracted Texas Medicaid claims administrator during the times in question in this case.

7. Texas Medicaid policy provides that all orthodontic services for which Medicaid coverage is sought must be preauthorized by TMHP.

8. In making preauthorization decisions in orthodontia cases, TMHP relies in part on a Handicapping Labio-lingual Deviation (HLD) score sheet to determine whether orthodontic services are medically necessary. The HLD score sheet is filled out by the provider and submitted to TMHP with the prior authorization request, along with other materials such as photographs and radiographs. The score sheet assigns 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.

9. The annual Texas Medicaid Provider Procedures Manual (Manual) provides guidance to providers about how to score their patients on the HLD sheet.

10. The Manual states that a minimum of 26 points on the HLD index is necessary to qualify for any orthodontic care.

11. The Manual states that dysfunction is a prerequisite for Medicaid coverage and that the intent of the Medicaid orthodontia program is to provide orthodontic care to clients with handicapping malocclusion.

12. The Manual also says, "Orthodontic services include the following: Correction of severe handicapping malocclusion as measured on the handicapping labial lingual deviation index."

13. The Texas Health and Human Services Commission, Office of Inspector General (HHSC-OIG) prosecutes fraud, waste, and abuse associated with the Texas Medicaid program.

14. In 2011, HHSC-OIG's staff (Staff) conducted a data analysis of paid Medicaid claims in Texas and determined that HFD was one of the top 25 providers in the state related to high utilization of orthodontia billing. Staff opened fraud investigations against those top 25 providers, including HFD.

15. An orthodontist retained by Staff, Charles Evans, D.D.S., reviewed the clinical records of 85 HFD patients for whom Medicaid prior authorization requests were filed with TMHP, and reimbursement paid, during the 2007 to 2011 time period.

16. The score sheets for the 85 patients at issue were filled out by the HFD orthodontia providers, Drs. Nguyen, Franklin, and Teegardin. In each case, the HFD provider scored the patient at 26 or more points. The greatest number of points was associated with the category of "ectopic eruption."

17. Dr. Evans concluded that in 84 of the 85 cases, the clinical records did not support the scoring on the HLD score sheets submitted with the preauthorization requests.

18. Dr. Evans scored far fewer points for ectopic eruption than did the HFD providers.

19. On the basis of Dr. Evans' review, on October 6, 2011, Staff placed a 40 percent payment hold on HFD's Medicaid reimbursement, based on an estimation that 40 percent of HFD's total Medicaid billing was for orthodontic (as opposed to other dentistry) services.

20. On September 28, 2011, Staff referred HFD to the Medicaid Fraud Control Unit of the Office of the Attorney General (MFCU).

21. On March 5, 2012, MFCU certified that HFD (among a number of providers) is still under investigation for fraud.

22. HFD requested a hearing concerning the 40 percent payment hold.

23. On February 3, 2012, the staff of the HHSC-OIG issued a notice of hearing to HFD. 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.

24. After a continuance, the hearing convened on April 24-25, 2012, before Administrative Law Judge (ALJ) Shannon Kilgore at the offices of the State Office of Administrative Hearings (SOAH) in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. HFD appeared through its attorneys of record, J.A. Canales and Oscar Garcia. Staff was represented by attorneys John Medlock and Corrie Alvarado. The record was left open until June 18, 2012, for the parties to file written closing arguments. The ALJ re-opened the record to require additional briefing on a legal issue, and the record finally closed on July 12, 2012.

25. The Manual has, for many years, defined 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."

26. The Manual's references to high labial cuspids and teeth grossly out of the long axis of the alveolar ridge are nonexclusive examples of ectopic eruption.

27. The Manual's definition of ectopic eruption is vague and requires the exercise of subjective judgment to interpret.

28. There is no evidence in the record indicating that there exists a widespread, non-Medicaid understanding of the specifics of the meaning of ectopic eruption among orthodontic providers.

29. Dr. Evans has treated no Medicaid patients and had no familiarity with the HLD score sheet prior to his work in this case.

30. Dr. Evans criticized the HFD providers' characterization of teeth as ectopic if the teeth were arguably on the alveolar ridge.

31. 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 HFD cases.

32. The Manual's definition of ectopic eruption was amended, to be effective after the times relevant to this case, to explicitly exclude 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.

33. 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.

34. 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.

35. There is no evidence that is credible, reliable, or verifying, or that has indicia of reliability, that HFD committed fraud or misrepresentation.

36. James Orr, D.D.S., a dentist and occlusion specialist who was the Texas Medicaid dental director for 9 years, reviewed the same 85 HFD cases reviewed by Dr. Evans.

37. Dr. Orr's opinions about the patients at issue are credible and reliable.

38. In Dr. Orr's opinion, in 8 of the 85 cases (or approximately 9 percent), the patients failed to meet the 26-point threshold for Medicaid coverage on the HLD score sheet.

39. Prima facie evidence exists that, as to approximately 9 percent of the HFD cases reviewed, HFD: billed or caused claims to be submitted to the Medicaid program for services or items that are not reimbursable by the Medicaid program; failed to comply with the terms of the Medicaid program provider agreement; and failed to comply with a Medicaid program procedure manual.

VII. 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. 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). "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(b).

5. "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. Tex. Gov't Code § 531.1011(1).

6. 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).

7. 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.

8. "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.

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

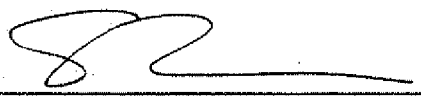
10. HHSC-OIG lacks authority to maintain the payment hold against HFD for alleged fraud or misrepresentation. Tex. Gov't Code § 531.102(g)(2); 42 C.F.R. § 455.23; Tex. Hum. Res. Code § 32.091(c); 1 Tex. Admin. Code §§ 371.1703(b)(3) and (5), 371.1617(a)(1)(A)-(C).

11. HHSC-OIG has authority to maintain a payment hold against HFD based on prima facie evidence of: billing or causing claims to be submitted to the Medicaid program for services or items that are not reimbursable by the Medicaid program; failing to comply with the terms of the Medicaid program provider agreement; and failing to comply with a Medicaid program procedure manual. 1 Tex. Admin. Code §§ 371. 1703(b)(5), 371.1617(1)(K), (5)(A) and (G).

VIII. RECOMMENDATION

The ALJ recommends that any payment hold against HFD be reduced to 9 percent of the 40 percent of HFD's total Medicaid reimbursement that is related to orthodontics, or 4 percent of HFD's total Medicaid reimbursement.

SIGNED August 15, 2012.



SHANNON KILGORE
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

PLEASE PRINT CLEARLY:

Patient 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	=
Labio-Lingual Spread in mm.				=
TOTAL				=

Diagnosis	For TMHP use only Authorization Number
Examiner:	Recorder:
Provider's Signature Please submit this score sheet with records	

APPENDIX 2

Patient No.[1]	Patient's First Initial	Provider's Score[2]	Evans' Score[3]	Orr's Score[4]
1	O	33	19	36
2	A	30	9	36
3	E	36	22	36
4	M	27	3	27
5	C	27	3	insufficient records
6	S	score sheet missing	26	46
7	D	score sheet missing	14	28 to infinite
8	M	31	16	32
9	Z	26	3	insufficient records
10	R	27	8	30
11	A	30	15	26
12	E	27	0	9
13	V	30	12	30
14	A	27	0	12-15
15	A	31	0	35
16	Y	26	13	30
17	G	30	24	36
18	F	27	6	28
19	A	36	16	36
20	T	30	13	27
21	J	27	5	27
22	B	30	16	30
23	K	31	11	36
24	A	30	13	not scored
25	C	27	14	39
26	D	29	9	26
27	S	27	13	27
28	S	30	16	30
29	A	33	3	38
30	S	28	9	30
31	C	27	14	27
32	T	score sheet missing	16	26
33	M	28	15	34
34	E	28	11	36
35	P	27	11	10

[1] As designated in Respondent's Ex. R-T.

[2] Respondent's Ex. R-T.

[3] Respondent's Ex. R-R; Petitioner's Ex. 13. Petitioner's Ex. 13 is a chart summarizing the scores reached by Drs. Evans and Orr. Where the ALJ has noticed discrepancies between this summary and the actual score sheets in evidence, the ALJ has relied on the actual score sheets.

[4] Respondent's Ex. R-SS; Petitioner's Exs. 13-14. Petitioner's Ex. 13 is a chart summarizing the scores reached by Drs. Evans and Orr. Where the ALJ has noticed discrepancies between this summary and the actual score sheets in evidence, the ALJ has relied on the actual score sheets.

APPENDIX 2

Patient No.[1]	Patient's First Initial	Provider's Score[2]	Evans' Score[3]	Orr's Score[4]
36	D	27	5	30
37	M	27	16	26
38	M	28	16	38
39	A	34	10	28
40	N	26	1	31
41	D	26	0	30
42	A	27	5	30
43	R	27	5	5
44	S	27	0	26
45	E	40	17	38
46	R	27	6	28
47	R	31	20	36
48	S	28	9	34
49	C	28	11	34
50	R	27	6	27
51	C	27	11	36
52	C	27	2	10
53	A	30	15	45
54	A	36	12	36
55	L	27	12	36
56	N	30	10	32
57	M	26	9	32
58	R	27	2	26
59	S	28	9	31
60	J	28	7	36
61	S	27	10	36
62	A	32	14	36
63	S	28	10	31
64	A	27	0	34
65	F	27	5	26
66	M	34	14	30
67	L	32	19	36
68	E	30	8	28
69	J	30	10	30
70	A	30	5	36
71	J	26	2	16
72	J	27	4	26
73	L	27	7	34
74	E	31	10	30
75	D	27	10	26
76	S	27	9	36
77	N	30	7	30
78	M	35	11	56
79	C	27	16	30
80	N	27	0	30
81	C	26	2	17
82	G	30	11	36
83	M	27	0	18
84	A	33	17	35
85	Y	30	12	30