FINAL PERFORMANCE AUDIT REPORT

Roberto Canales, M.D. P.A.

Billing Provider NPI: 1023237518
Billing Provider Tax ID: 742298260

1733 Curie Drive, Suite 103
El Paso, Texas 79902

Final Report Date: August 30, 2023

OIG Report No. AUD-23-036

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Table of Contents

Page

Transmittal Letter to Texas Health and Human Services Commission 1

Audit Background 2

Methodology and Scope 4

Results 8

Recommendations and Management's Response 12

Final Overpayment Based on Management's Response 14

August 30, 2023

To the Texas Health and Human Services Commission, Office of the Inspector General:

Weaver has completed the Final Performance Audit Report for Roberto Canales, M.D. P.A. (Roberto Canales) Medicaid and CHIP claims for pediatric telemedicine services paid by El Paso Health (EPH) and Superior Health Plan (Superior) with dates of services beginning September 1, 2021 through August 31, 2022. The objective of this audit was to determine whether services billed and paid under the state Medicaid program were provided in accordance with applicable state and federal Medicaid laws, regulations, rules, policies, and contractual requirements. The specific state and Federal Medicaid law, regulations, rules, policies, and contractual requirements to be tested were agreed to by Texas Health and Human Services Commission, Office of the Inspector General ("HHSC-OIG") in the approved audit test plan.

Our audit was performed under Weaver's Master Contract #HHS000006800001 and Work Order/Contract #HHS000006800008 with HHSC.

Weaver conducted this audit in accordance with the performance audit provisions of Generally Accepted Government Auditing Standards ("GAGAS") issued by the Comptroller General of the United States and applicable Texas Administrative Code ("TAC") rules. Those standards require that Weaver plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe the evidence obtained during the course of this performance audit provides a reasonable basis for the findings and conclusions based on the audit objective and tests identified in this report.

Management responses from Roberto Canales are included in Weaver's Final Performance Audit Report.

The purpose of this performance audit report is to clearly communicate the results of the audit to those charged with governance, Roberto Canales' management, and the appropriate oversight officials.

If we can provide additional assistance or answer questions regarding this report, please contact us.

Sincerely,

Weaver and Tidwell, L.L.P.

WEAVER AND TIDWELL, L.L.P.

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Audit Background

Weaver was engaged by the Texas Health and Human Services Commission (HHSC) Office of the Inspector General (HHSC-OIG) to conduct performance audits of Medicaid claims billed by providers and paid by the state Medicaid program. This performance audit focused on Medicaid and CHIP claims paid to Roberto Canales, MD, PA (Roberto Canales) for pediatric telemedicine services paid by managed care organizations (MCOs) El Paso Health (EPH) and Superior Health Plan (Superior) with dates of services beginning September 1, 2021 through August 31, 2022. The scope of this performance audit was determined based on Weaver's independent review and analysis of paid claims data for pediatric telemedicine providers and discussions with HHSC-OIG.

Audited Entity

Canales is a pediatric clinic that provides primary care in El Paso, Texas. [1] It is our understanding as of the date of this report that Roberto Canales:

- Holds a current business and practitioner license.
- Is not involved with potential ongoing investigations.
- Is not listed as being excluded by the U.S. Department of Health and Human Services, OIG (DHHS-OIG).[2]
- Does not have a corporate integrity agreement in place under the DHHS-OIG.[3]
- Does not appear in any audit-related news articles and press releases.

Description of Services

Telemedicine Services

The Texas Medicaid Provider Procedures Manual, Telecommunication Services Handbook in effect during the audit period describes telemedicine services as[4]:

> *Telemedicine medical services are defined as health-care services delivered by a physician licensed in Texas or a health professional who acts under the delegation and supervision of a health professional licensed in Texas and within the scope of the health professional's license to a patient at a different physical location using telecommunications or information technology.*

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[1] https://www.md.com/doctor/roberto-canales-md?fbclid=IwAR0aBKdBV39hgHt-lY-d7Wi7t9K_1I96Iq8T2YE1ZeafZTtsw85ip3mf800.
[2] https://exclusions.oig.hhs.gov/Default.aspx.
[3] https://www.oig.hhs.gov/compliance/corporate-integrity-agreements/cia-documents.asp.
[4] Telecommunication Services Handbook, Texas Medicaid Providers Procedures Manual: Vol. 2, Section 3.

THSteps

The Texas Medicaid Provider Procedures Manual, Children's Services Handbook in effect during the audit period provides the following overview of THSteps[5]:

> *The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive preventive child health service for clients who are birth through 20 years of age. In Texas, EPSDT is known as THSteps and includes periodic screening, vision, hearing, and dental preventive and treatment services. EPSDT was created by the 1967 amendments to the federal Social Security Act and defined by the Omnibus Budget Reconciliation Act (OBRA) of 1989. The periodic screening for a checkup consists of five federally required components as noted on the THSteps Periodicity Schedule. In addition, Section 1905(r)(5) of the Social Security Act (SSA) requires that any medically necessary health-care service listed in the Act be provided to EPSDT clients even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. A service is medically necessary when it corrects or ameliorates the client's disability, physical or mental illness, or chronic condition.*

Objective

The audit objective was to determine whether services billed and paid under the state Medicaid program were provided in accordance with applicable state and federal Medicaid laws, regulations, rules, policies, and contractual requirements.

Criteria, Standards, and Guidance

The specific state and federal Medicaid laws, regulations, rules, policies, and contractual requirements that Weaver relied upon for this performance audit were agreed upon by HHSC-OIG in the approved audit test plan and are identified in **Attachment B**.

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[5] Children's Services Handbook, Texas Medicaid Providers Procedures Manual: Vol. 2, Section 4.

Methodology and Scope

This audit was conducted in accordance with the performance audit provisions of Generally Accepted Government Auditing Standards ("GAGAS") and applicable Texas Administrative Code ("TAC") rules, which require that Weaver plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective.

Internal Controls Testing

To address GAGAS, which require those conducting performance audits to identify and document internal controls related to the audit objectives, Weaver obtained an understanding through inquiries and discussions with the provider, Canales' overall internal control structure significant to the audit objective including:

- The **Control Environment** is the foundation for an internal control system. It provides the discipline and structure to help an entity achieve its objectives.
- **Control Activities** are the actions management establishes through policies and procedures to achieve objectives and respond to risks in the internal control system, which includes the entity's information systems.
- **Monitoring** includes activities management establishes and operates to assess the quality of performance over time and promptly resolve the findings of audits and other reviews.

Audit Tests

Weaver conducted inquiries, inspection, and testing of documents and records to perform the following tests:

Members

- M-1 Was the member enrolled in Texas Medicaid at the time the billed service was provided?
- M-2 Was the claim for a Medicaid covered benefit (age, program, and benefit limitation)?
- M-3 Was the member under age 21?

Providers

- P-1 Was the billing provider enrolled as a Texas Medicaid provider?
- P-2 Was the rendering provider enrolled as a Texas Medicaid provider or supervised by someone who was an enrolled provider?
- P-3 Was the provider licensed, trained, or supervised appropriately to render the billed service?

Medical Records

- R-1 Were the requested medical records provided to the auditors?
- R-2 Was there an informed consent form signed by the member or the member's guardian?
- R-3 Was the informed consent form signed by the member or the member's guardian before the services were provided?
- R-4 Does evidence in the medical record indicate the billed service was delivered to the member?
- R-5 Does documentation within the progress notes support Current Procedural Terminology ("CPT") procedures codes and units billed and paid?
- R-6 Do medical records supporting the billed claim contain evidence that requirements for diagnosis codes, modifiers, documentation, and exclusions were met?
- R-7 Do medical records supporting the billed claim contain evidence that privacy notice and security requirements were met?

Billing

- B-1 Was prior authorization, if required, obtained before services were delivered?
- B-2 Was the rendering provider name on the claim the same as the provider who performed the service?
- B-3 Were the services billed and paid at the correct amount – specific to the program, the MCO, the rates contained in the MCO's contract with the provider, and rate limitations based on licensure?
- B-4 Were billed lab or radiology services ordered by the rendering provider?

HHSC-OIG also identified certain risk areas for consideration during this performance audit:

- High-Level and Prolonged Service via Telemedicine
- Laboratory and Diagnostic Testing

Audited Claims

Weaver's audit scope included 13,663 claim line items (with a payment over $25) totaling $623,078 paid to Canales by EPH and Superior with dates of services beginning September 1, 2021 through August 31, 2022. The paid claims data for audited claims was provided by HHSC-OIG and is summarized in **Table 1**.

Table 1: Summary of Paid Claims Data

Stratum (Claims Universe)	Number of Paid Claims	Total Paid	Average Claim Value
EPH			
High Level and Prolonged E&M	1,796	$106,101.55	$59.08
THSteps	38	3,620.16	95.27
E&M	5,234	202,941.77	38.77
EPH Total	**7,068**	**$312,663.48**	**$44.24**
Superior			
High Level and Prolonged E&M	1,599	$92,926.51	$58.12
Lab or Radiology	13	733.98	56.46
Other	384	38,400.00	100.00
THSteps	70	6,219.36	88.85
E&M	4,529	172,134.18	38.01
Superior Total	**6,595**	**$310,414.03**	**$47.07**
Total Claims	**13,663**	**$623,077.51**	**$45.60**

Sample Design

Based on a review of the paid claims data and the risks identified by HHSC-OIG, Weaver determined that a statistically valid stratified random sample was an efficient, effective and reliable method to test claim line items.

Stratified Random Sampling Methodology

The claim line items were stratified by MCO (EPH and Superior). The sample size for each claims universe ("EPH – All Claims" and "Superior – All Claims") was calculated using a commonly-utilized statistical formula that determines the minimum sample size to estimate a population proportion from a finite population. Weaver utilized a 95% confidence level, 25% estimated error rate, and a $4.00 margin of error (approximately 10% of the average claim value) which resulted in a sample size of 101 claim line items for the "EPH – All Claims" universe and 130 claim line items for the "Superior – All Claims" universe.

Then, utilizing the sample size for each MCO claim universe (101 claim line items for the "EPH – All Claims" universe and 130 claim line items for the "Superior – All Claims" universe), Weaver sub-stratified each claim universe by Current Procedural Terminology (CPT) code groupings to

ensure that the sample selection addressed certain risks identified by OIG in its preliminary analysis and described in Weaver's Audit Test Plan.

Each MCO claim universe was sub-stratified by the following CPT code categories:

- High Level and Prolonged Evaluation & Management (E&M)
- Lab or Radiology
- THSteps
- Evaluation & Management (E&M)
- Other

The sample size for each CPT code sub-stratum was generated from RAT-STATS Stratified Variable Sample Size Determination Calculator.[6] In instances where RAT-STATS generated a sample size of less than 5 for a particular sub-stratum, Weaver utilized a minimum sample size of 5 claim line items. Then, Weaver utilized RAT-STATS to generate a random sample of claim line items from each CPT code sub-stratum.

Table 2 summarizes the sample claim line items reviewed by Weaver in conducting its performance audit.

Table 2: Summary of Sample Claims

Stratum (Claims Universe)	Number of Paid Claims	Total Paid	Average Claim Value
EPH			
High Level and Prolonged E&M	20	$1,175.57	$58.78
THSteps	5	504.81	100.96
E&M	76	2,952.44	38.85
EPH Total	**101**	**$4,632.82**	**$45.87**
Superior			
High Level and Prolonged E&M	22	$1,315.57	$59.80
Lab or Radiology	5	282.30	56.46
Other	5	500.00	100.00
THSteps	5	455.78	91.16
E&M	93	3,568.24	38.37
Superior Total	**130**	**$6,121.89**	**$47.09**
Total Claims	**231**	**$10,754.71**	**$46.56**

[6] RAT-STATS is a software package developed by the Federal Department of Health and Human Services Office of Inspector General to assist providers in claim review. The software assists users in determining sample sizes, selecting random samples, and extrapolating the results. RAT-STATS Stratified Variable Sample Size Determination Calculator distributes the predetermined sample size for each claim universe across the strata based on optimal allocation formulas.

Audit Results

We believe the evidence obtained during the course of this performance audit provides a reasonable basis for the findings and conclusions based on the audit objective and tests identified in this report. Our findings and conclusions are limited to the issues tested and errors identified within this report. This performance audit was not intended to discover all possible errors or unacceptable practices. Due to the limited nature of this performance audit, Weaver has not made any inferences with respect to Canales' overall level of performance.

Our findings may result in an overpayment determination or a non-monetary administrative finding. One claim may have multiple findings. The Draft Performance Audit Report identified exceptions for 32 out of 231 sample claim line items that resulted in an overpayment or underpayment determination and noted additional administrative findings that resulted in certain recommendations. Weaver provided a copy of the Draft Performance Audit Report to Canales on August 7, 2023.

An exit conference was held on August 15, 2023 to discuss the findings and recommendations contained in the Draft Performance Audit Report. In response to the Draft Performance Audit Report and exit conference, Canales provided additional information related to the findings for the sample claim line items. On August 21, 2023, Canales provided its "Response to Audit Report" in which Canales responded to the findings contained in the Draft Performance Audit Report.

For each test, Weaver has included the preliminary findings that were noted in the Draft Performance Audit Report and identified instances when the findings were updated. Our final findings for each test are denoted in bold font. Weaver's final findings identified exceptions for 28 out of 231 sample claim line items that resulted in a net overpayment of $1,798.76 and noted additional administrative findings. Specific findings for each sample claim are shown in **Attachment A**.

Test: M-1 Was the member enrolled in Texas Medicaid at the time the billed service was provided?

- **Canales did not provide documentation that identified and supported the Medicaid identification number in the paid claims data for 156 sample claim line items. Because Canales provided sufficient information to verify the identity of the patients associated with the sample claim line items (name, date of birth, etc.), this results in an administrative finding.**

M-2 Was the claim for a Medicaid covered benefit (age, program and benefit limitation)?

- **There are no findings, issues, or recommendations related to this test.**

M-3 Was the member under age 21?

- **There are no findings, issues, or recommendations related to this test.**

P-1 Was the billing provider enrolled as a Texas Medicaid provider?

- **There are no findings, issues, or recommendations related to this test.**

P-2 Was the rendering provider enrolled as a Texas Medicaid provider or supervised by an enrolled provider?

- Canales did not provide documentation that the rendering provider for 3 sample claim line items was enrolled as a Texas Medicaid provider on the date that services were provided to members. This results in an overpayment determination in the amount of $125.72
- **The paid claims data and documentation provided by Canales identified the rendering provider as Shelley Lazaro, MD for all 3 sample claim line items that resulted in an overpayment determination for this test. Based on the information provided by Canales, there appears to be a lapse in enrollment for Dr. Lazaro from July 20, 2022 through August 14, 2022. While TMPPM allows providers to continue to file claims while they are enrolled and completing the revalidation process, providers must complete the revalidation process before the end of their enrollment period or they will be disenrolled and claims should not be paid. Canales did not provide documentation that Dr. Lazaro completed the revalidation process prior to the end of her enrollment period. However, based on guidance from OIG after the exit conference, for purposes of this performance audit, these will be considered administrative findings.**[7]

P-3 Was the provider licensed, trained, or supervised appropriately to render the billed service?

- **There are no findings, issues, or recommendations related to this test.**

R-1 Were the requested medical records provided to the auditors?

- **Other than specific exceptions noted, there are no findings, issues, or recommendations related to this test.**

R-2 & R-3 Was there an informed consent form signed by the member or the member's guardian? And, was the informed consent form signed by the member or the member's guardian before the services were provided?

- **Canales did not provide a signed consent form for 24 sample claim line item. This results in an overpayment determination in the amount of $1,762.55.**

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[7] Paid Claims Data included 105 claim line items in the claims universes totaling $4,027.15 for services rendered by Dr. Lazaro during the lapse in enrollment. 3 of the 105 claims line items totaling $125.72 were sample claim line items.

R-4 Does evidence in the medical records indicate the billed service was performed?

- **There are no findings, issues, or recommendations related to this test.**

R-5 Does documentation within the progress notes support Current Procedural Terminology (CPT) procedures codes and units billed and paid?

- **There are no findings, issues, or recommendations related to this test.**

R-6 Do medical records supporting the billed claim contain evidence that requirements for diagnosis codes, modifiers, documentation, and exclusions were met?

- **Weaver identified 4 instances where the diagnosis was not properly documented in the medical records. In these instances, the patient received a telemedicine and curbside COVID-19 test followed by an in-person THSteps visit. For these claims, the telemedicine and curbside visit was billed as THSteps and given a diagnosis from that THSteps visit, indicating the diagnosis was mismatched between the visits. Because this did not affect the billing of the claim, these will be considered administrative findings.**
- **Including the 4 instances identified above, Weaver identified 23 instances where the place of service documented in the medical record does not indicate that this was a telehealth visit. However, the amount that would have been paid for an office visit is the same as the amount paid; therefore, this will be considered an administrative finding.**
- **Including the 4 instances identified above, Weaver identified 22 instances where the modifier 95 (for Telemedicine claims) was used, but the claims were in-person. However, the amount that would have been paid for an office visit is the same as the amount paid; therefore, this will be considered an administrative finding.**

R-7 Do medical records supporting the billed claim contain evidence that privacy notice and security requirements were met?

- Canales did not provide the members' privacy form for 1 claim line item. This results in an overpayment determination in the amount of $42.16.
- **After reviewing additional documents provided by Canales after the exit conference, Weaver determined that there were no findings, issues, or recommendations related to this test.**

B-1 Was prior authorization, if required, obtained before services were delivered?

- **There are no findings, issues, or recommendations related to this test.**

B-2 Was the rendering provider name and NPI on the claim the same as the provider who performed the service?

- **Weaver was unable to identify the rendering provider for 1 claim on the claim's date of service. This results in an overpayment determination in the amount of $41.40**
- **The paid claims data provided the incorrect rendering provider name for 26 claim line items; however, Weaver was able to identify the correct rendering provider from the medical records to perform all of the relevant enrollment and licensing tests. Therefore, Weaver has considered these findings to be administrative.**

B-3 Were the services billed and paid at the correct amount – specific to the program, the MCO, the rates contained in the MCO's contract with the provider, and rate limitations based on licensure?

- **Canales was paid the incorrect rate for 8 sample claim line items. This resulted in a net overpayment determination in the amount of $7.97**

B-4 Were billed lab or radiology services ordered by the rendering provider?

- **There are no findings, issues, or recommendations related to this test.**

Recommendations and Management's Responses

Recommendations

- Canales should return overpayments to HHSC-OIG pursuant to its instructions for repayment.
- Canales should ensure, before submitting claims to a managed care organization for services provided to Texas Medicaid members, that medical records include documentation of the member's Texas Medicaid identification number.
- Canales should ensure that the rendering provider is enrolled as a Texas Medicaid provider or supervised by an enrolled provider as of the respective date of service for their claims.
- Canales should ensure that all sections of the informed consent form have been completed and that the informed consent form is signed by the member or the member's guardian. If a properly completed informed consent form does not exist, obtain a signed informed consent form from the member or the member's guardian before any additional services are delivered.
- Canales should ensure before submitting claims to a managed care organization for services provided to Texas Medicaid members, that the correct diagnosis, place of service and modifiers are appropriate and consistent with the medical records.
- Canales should ensure that claims accurately identify the rendering provider prior to submitting claims to a managed care organization.
- Canales should develop processes for reviewing payments received from managed care organizations to ensure that Canales is receiving payments consistent with fee schedules. Canales should identify and refund any overpayments to the managed care organization within contractual timelines.

Management's Response

Edinburg responded as follows to tests that resulted in findings:

M-1: Was the member enrolled in Texas Medicaid at the time the billed service was provided?

- *Management recognizes and acknowledges the risks noted in the administrative findings and will address the risks noted therein.*

P-2: Was the rendering provider enrolled as a Texas Medicaid provider or supervised by an enrolled provider?

- *The three sample claim line items were removed from the sample claims following the Audit Exit Conference based on CMS guidance.*

R-2& R-3: Was there an informed consent form signed by the member or the member's guardian? And, was the informed consent form signed by the member or the member's guardian before the services were provided?

- *These were in-person visits in which the parent and/or guardian of the child signed in the child, requesting treatment from Roberto Canales, M.D. P.A. At that time the superbill is printed before a provider is assigned. The parent/guardian signs the superbill and then a provider is assigned based on preference or at the request of the parent/guardian, if no preference then it is based on whichever provider is the next available. The practice accepts many walk-in patients throughout the day.*

- *Management recognizes and acknowledges the risks noted in the findings and will address the risks noted therein.*

R-6: Do the medial records supporting the billed claim contain evidence that requirements for diagnosis codes, modifiers, documentation, and exclusions were met?

- *Management recognizes and acknowledges the risks noted in the three separate administrative findings and will address the risks noted therein.*

R-7: Do medical records supporting the billed claim contain evidence that privacy notice and security requirements were met?

- *The single claim line item was cleared prior to the Audit Exit Conference by providing the missing privacy notice.*

B-2: Was the rendering provider name and NPI on the claim the same as the provider who performed the service?

- *The rendering provider of these claims was a Nurse Practitioner that has now retired, Kathleen Foster. It was billed as Dr. Roberto Canales as supervising of Kathleen Foster. In the sample explanation of benefits provided ("Proof on consent for patient Vela" sent to Samuel Cooper on 8/17/2023) you can see that the Health Groups are aware of who is rendering and who is billing.*

- *Management recognizes and acknowledges the risks noted in the administrative findings and will address the risks noted therein.*

B-3: Were the services billed and paid at the correct amount – specific to the program, the MCO, the rates contained in the MCO's contract with the provider, and rate limitations based on licensure?

- *Management is still waiting to hear back from El Paso First and Superior regarding all the amendments during that time.*

Final Overpayment Based on Management's Response

Upon consideration of additional documents and information provided by Canales and discussions with OIG, Weaver identified exceptions for 28 out of 231 sample claim line items, or 12%, of the sample claim line items. The total overpayment calculated from the sample claim line items is $1,798.76, or approximately 17% of the amount paid for sample claim line items. The overpayments for each stratum are summarized in **Table 3**:

Table 3: Sample Claims with Overpayment Determination

Stratum (Claims Universe)	Sample Claims	Overpayment Amount
EPH		
High Level and Prolonged E&M	6	$355.20
THSteps	5	504.81
E&M	0	-
EPH Total	**11**	**$860.01**
Superior		
High Level and Prolonged E&M	6	$348.90
Lab or Radiology	1	56.46
Other	0	0.00
THSteps	5	455.78
E&M	5	77.61
Superior Total	**17**	**$938.75**
Total Claims	**28**	**$1,798.76**

Extrapolation of Sample Results

The overpayment shown in Table 3 is only applicable to the sampled claims. Pursuant to 1 TAC §371.35 and based on discussions with HHSC-OIG, Weaver utilized RAT-STATS to extrapolate the results from the sample claims. **Based on the lower limit of a one-sided 90% confidence interval, the total extrapolated overpayment is $45,096.21, comprised of an overpayment of $21,488.08 for the "EPH – All Claims" universe and $23,608.12 for the "Superior – All Claims" universe.**[8]

In addition, other audit issues identified in the Final Performance Audit Report may be subject to HHSC-OIG administrative enforcement measures[9], including administrative penalties.[10]

[8] Since RAT-STATS generates two-sided results, based on discussions with OIG, Weaver used the value for the lower limit of a two-sided 80% confidence interval to estimate the overpayment.
[9] 1 Tex. Admin. Code § 371.1603 (May 1, 2016, amended May 20, 2020).
[10] Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

Roberto Canales M.D. P.A.
Summary of Findings

"A" indicates Administrative Issue.

Weaver Sample Claim Number	Weaver Stratum	MCO Name	Full Claim Number	Date of Service	Member Full Name	Detail Paid Procedure Code	Rendering Provider Based on Weaver Review	Provider Type	Detail Paid Amount	M-1	P-2	R-2	R-3	R-6	B-2	B-3	Overpayment
1	E&M	EL PASO HEALTH				99213		Physician	$42.16								$0.00
2	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
3	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
4	E&M	EL PASO HEALTH				99213		APRN-CP	42.16						A		0.00
5	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
6	E&M	EL PASO HEALTH				99213		Physician	42.16	A							0.00
7	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
8	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
9	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
10	E&M	EL PASO HEALTH				99213		Physician	39.52								0.00
11	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
12	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
13	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
14	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
15	E&M	EL PASO HEALTH				99212		Physician	28.04								0.00
16	E&M	EL PASO HEALTH				99212		Physician	28.04								0.00
17	E&M	EL PASO HEALTH				99212		APRN-CP	28.04	A					A		0.00
18	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
19	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
20	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
21	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
22	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
23	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
24	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
25	E&M	EL PASO HEALTH				99213		APRN-CP	42.16						A		0.00
26	E&M	EL PASO HEALTH				99212		APRN-CP	25.80	A							0.00
27	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
28	E&M	EL PASO HEALTH				99213		Physician	39.52	A							0.00
29	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
30	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
31	E&M	EL PASO HEALTH				99213		Physician	42.16	A							0.00
32	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
33	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
34	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
35	E&M	EL PASO HEALTH				99212		APRN-CP	25.80								0.00
36	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
37	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
38	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
39	E&M	EL PASO HEALTH				99212		Physician	28.04								0.00
40	E&M	EL PASO HEALTH				99212		Physician	28.04								0.00
41	E&M	EL PASO HEALTH				99213		APRN-CP	42.16						A		0.00
42	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
43	E&M	EL PASO HEALTH				99212		Physician	28.04	A							0.00
44	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
45	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
46	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
47	E&M	EL PASO HEALTH				99213		APRN-CP	42.16						A		0.00
48	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
49	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
50	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
51	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
52	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
53	E&M	EL PASO HEALTH				99213		APRN-CP	42.16						A		0.00
54	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
55	E&M	EL PASO HEALTH				99212		Physician	28.04								0.00
56	E&M	EL PASO HEALTH				99213		APRN-CP	42.16						A		0.00
57	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
58	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
59	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
60	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
61	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
62	E&M	EL PASO HEALTH				99212		Physician	28.04	A							0.00
63	E&M	EL PASO HEALTH				99212		APRN-CP	25.80								0.00
64	E&M	EL PASO HEALTH				99213		APRN-CP	42.16						A		0.00
65	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
66	E&M	EL PASO HEALTH				99213		Physician	42.16		A						0.00
67	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
68	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
69	E&M	EL PASO HEALTH				99212		Physician	28.04								0.00
70	E&M	EL PASO HEALTH				99213		Physician	42.16		A						0.00
71	E&M	EL PASO HEALTH				99212		APRN-CP	25.80								0.00
72	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
73	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
74	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
75	E&M	EL PASO HEALTH				99213		APRN-CP	38.79								0.00
76	E&M	EL PASO HEALTH				99213		Physician	42.16								0.00
77	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
78	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
79	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
80	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
81	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00

Roberto Canales M.D. P.A.
Summary of Findings

"A" indicates Administrative Issue.

Weaver Sample Claim Number	Weaver Stratum	MCO Name	Full Claim Number	Date of Service	Member Full Name	Detail Paid Procedure Code	Rendering Provider Based on Weaver Review	Provider Type	Detail Paid Amount	M-1	P-2	R-2	R-3	R-6	B-2	B-3	Overpayment
82	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A		59.20	A	A			59.20
83	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
84	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
85	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
86	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
87	High Level and Prolonged E&M	EL PASO HEALTH				99214		APRN-CP	54.47	A							0.00
88	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
89	High Level and Prolonged E&M	EL PASO HEALTH				99214		APRN-CP	55.50	A					A		0.00
90	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
91	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A							0.00
92	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A		59.20	A	A			59.20
93	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A		59.20	A	A			59.20
94	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A		59.20	A	A			59.20
95	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A		59.20	A	A			59.20
96	High Level and Prolonged E&M	EL PASO HEALTH				99214		Physician	59.20	A		59.20	A	A			59.20
97	THSteps	EL PASO HEALTH				99393		Physician	97.43	A		97.43	A	A		2.54	97.43
98	THSteps	EL PASO HEALTH				99393		Physician	97.43	A		97.43	A	A		2.54	97.43
99	THSteps	EL PASO HEALTH				99393		Physician	97.43	A		97.43	A	A		2.54	97.43
100	THSteps	EL PASO HEALTH				99394		Physician	106.26	A		106.26	A	A		2.77	106.26
101	THSteps	EL PASO HEALTH				99394		Physician	106.26	A		106.26	A	A		2.77	106.26
102	E&M	SUPERIOR				99212		Physician	27.54								0.00
103	E&M	SUPERIOR				99213		APRN-CP	36.36							(1.73)	(1.73)
104	E&M	SUPERIOR				99212		APRN-CP	27.54						A		0.00
105	E&M	SUPERIOR				99213		APRN-CP	36.36							(1.73)	(1.73)
106	E&M	SUPERIOR				99213		APRN-CP	36.36							(1.73)	(1.73)
107	E&M	SUPERIOR				99213		APRN-CP	41.40	A					A		0.00
108	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
109	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
110	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
111	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
112	E&M	SUPERIOR				99212		Physician	27.54	A							0.00
113	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
114	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
115	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
116	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
117	E&M	SUPERIOR				99213		APRN-CP	38.09								0.00
118	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
119	E&M	SUPERIOR				99212		Physician	27.54	A							0.00
120	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
121	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
122	E&M	SUPERIOR				99213		APRN-CP	41.40	A					A		0.00
123	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
124	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
125	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
126	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
127	E&M	SUPERIOR				99212		Physician	27.54	A							0.00
128	E&M	SUPERIOR				99213		Physician	41.40	A		41.40	A	A			41.40
129	E&M	SUPERIOR				99213		APRN-CP	38.09	A					A		0.00
130	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
131	E&M	SUPERIOR				99212		APRN-CP	25.34	A							0.00
132	E&M	SUPERIOR				99213		APRN-CP	41.40	A							0.00
133	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
134	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
135	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
136	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
137	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
138	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
139	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
140	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
141	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
142	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
143	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
144	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
145	E&M	SUPERIOR				99213		APRN-CP	41.40	A					A		0.00
146	E&M	SUPERIOR				99213		APRN-CP	41.40	A					A		0.00
147	E&M	SUPERIOR				99212		Physician	27.54	A							0.00
148	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
149	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
150	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
151	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
152	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
153	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
154	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
155	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
156	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
157	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
158	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
159	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
160	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
161	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
162	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00

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Summary of Findings

"A" indicates Administrative Issue.

Weaver Sample Claim Number	Weaver Stratum	MCO Name	Full Claim Number	Date of Service	Member Full Name	Detail Paid Procedure Code	Rendering Provider Based on Weaver Review	Provider Type	Detail Paid Amount	M-1	P-2	R-2	R-3	R-6	B-2	B-3	Overpayment
163	E&M	SUPERIOR				99213		N/A	41.40	A					41.40		41.40
164	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
165	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
166	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
167	E&M	SUPERIOR				99212		Physician	27.54	A							0.00
168	E&M	SUPERIOR				99213		Physician	41.40	A					A		0.00
169	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
170	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
171	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
172	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
173	E&M	SUPERIOR				99212		Physician	27.54	A							0.00
174	E&M	SUPERIOR				99212		APRN-CP	27.54	A					A		0.00
175	E&M	SUPERIOR				99213		APRN-CP	41.40	A					A		0.00
176	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
177	E&M	SUPERIOR				99213		Physician	41.40	A					A		0.00
178	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
179	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
180	E&M	SUPERIOR				99212		APRN-CP	27.54	A					A		0.00
181	E&M	SUPERIOR				99212		Physician	27.54	A							0.00
182	E&M	SUPERIOR				99212		APRN-CP	25.34	A							0.00
183	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
184	E&M	SUPERIOR				99213		Physician	41.40	A	A						0.00
185	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
186	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
187	E&M	SUPERIOR				99213		APRN-CP	41.40	A					A		0.00
188	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
189	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
190	E&M	SUPERIOR				99213		Physician	41.40	A							0.00
191	E&M	SUPERIOR				99212		APRN-CP	25.34	A							0.00
192	E&M	SUPERIOR				99213		Physician	41.40	A					A		0.00
193	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
194	E&M	SUPERIOR				99213		APRN-CP	38.09	A							0.00
195	High Level and Prolonged E&M	SUPERIOR				99214		APRN-CP	58.15	A					A		0.00
196	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
197	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A		58.15	A	A			58.15
198	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A		58.15	A	A			58.15
199	High Level and Prolonged E&M	SUPERIOR				99204		Physician	99.08	A							0.00
200	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
201	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
202	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
203	High Level and Prolonged E&M	SUPERIOR				99214		APRN-CP	53.49	A							0.00
204	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
205	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
206	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A		58.15	A	A			58.15
207	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
208	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
209	High Level and Prolonged E&M	SUPERIOR				99214		APRN-CP	58.15	A					A		0.00
210	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
211	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
212	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
213	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A							0.00
214	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A		58.15	A	A			58.15
215	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A		58.15	A	A			58.15
216	High Level and Prolonged E&M	SUPERIOR				99214		Physician	58.15	A		58.15	A	A			58.15
217	Lab or Radiology	SUPERIOR				87635		APRN-CP	56.46	A					A		0.00
218	Lab or Radiology	SUPERIOR				87635		Physician	56.46	A							0.00
219	Lab or Radiology	SUPERIOR				87635		Physician	56.46	A							0.00
220	Lab or Radiology	SUPERIOR				87635		Physician	56.46	A							0.00
221	Lab or Radiology	SUPERIOR				87635		Physician	56.46	A		56.46	A	A			56.46
222	Other	SUPERIOR				99050		Physician	100.00	A							0.00
223	Other	SUPERIOR				99050		Physician	100.00	A							0.00
224	Other	SUPERIOR				99050		Physician	100.00	A							0.00
225	Other	SUPERIOR				99050		APRN-CP	100.00	A							0.00
226	Other	SUPERIOR				99050		Physician	100.00	A							0.00
227	THSteps	SUPERIOR				99392		APRN-CP	80.23	A		80.23	A	A	A		80.23
228	THSteps	SUPERIOR				99394		Physician	93.51	A		93.51	A	A			93.51
229	THSteps	SUPERIOR				99393		Physician	93.19	A		93.19	A	A			93.19
230	THSteps	SUPERIOR				99392		Physician	87.21	A		87.21	A	A			87.21
231	THSteps	SUPERIOR				99394		Physician	101.64	A		101.64	A	A			101.64
								Total	**$10,754.71**	**$0.00**		**$1,762.55**	**$0.00**	**$0.00**	**$41.40**	**$7.97**	**$1,798.76**
								Overpayment Determination	**231**	**0**	**0**	**24**	**0**	**0**	**1**	**8**	**28**
								Administrative Finding		156	3	0	24	24	26	0	0

Roberto Canales M.D. P.A.
Criteria, Standards, and Guidance

The following specific state and federal Medicaid laws, regulations, rules, policies, and contractual requirements to be tested were agreed to by the HHSC-OIG in the approved audit test plan:

		Description	Tests
I		**Generally Accepted Government Auditing Standards (GAGAS)**	
II		**Federal Criteria**	
	II.A	42 U S. Code §1396u-2 (d)(6)(A), (6) Enrollment of Participating Providers	**P-1, P-2**
	II.B	CMS Medicaid Provider Enrollment Compendium (MPEC) 1.5.1, C, 1	**P-2**
III		**Texas Medicaid Provider Procedures Manual**	
	III.A	Volume 1, Section 1: Provider Enrollment and Responsibilities	**P-1, P-2, R-1**
	III.B	Volume 1, Section 2: Texas Medicaid Fee-For-Service Reimbursement	**B-3**
	III.C	Volume 1, Section 3: TMHP Electronic Data Interchange (EDI)	**R-6**
	III.D	Volume 1, Section 4: Eligibility	**M-1, M-2**
	III.E	Volume 1, Section 6: Claims Filing	**P-2, R-6, B-2**
	III.F	Volume 2 - Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook	**P-2, B-1**
	III.G	Texas Medicaid and CHIP Reference Guide, Texas Health and Human Services Commission, Chapter 1: Who can get Medicaid or CHIP, and how can they get it?	**M-2**
IV		**Texas Administrative Code (TAC)**	
	IV.A	Title 1 (Administration), Part 15 (Texas Health and Human Services Commission), Chapter 354 (Medicaid Health Services), Subchapter A (Purchased Health Services), Division 1 (Medicaid Procedures for Providers), §354.1001 – §354.1005	**P-3, R-1,R-4, R-5, B-2**
	IV.B	Title 1 (Administration), Part 15 (Texas Health and Human Services Commission), Chapter 354 (Medicaid Health Services), Subchapter A (Purchased Health Services), Division 29 (Licensed Professional Counselors, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists), §354.1382	**P-3**
	IV.C	Title 1 (Administration), Part 15 (Texas Health and Human Services Commission), Chapter 355 (Reimbursement Rates), Subchapter J (Purchased Health Services), Division 5 (General Administration), §355.8085 and §355.8091	**P-3, R-6, B-2, B-3**
	IV.D	Title 1 (Administration), Part 15 (Texas Health and Human Services Commission), Chapter 355 (Reimbursement Rates), Subchapter J (Purchased Health Services), Division 14 (Federally Qualified Health Center Services), §355.8261	**R-6**
	IV.E	Title 22 (Examining Boards), Part 9 (Texas Medical Board), Chapter 174.4 (Notice to Patients)	**R-7**
	IV.F	Title 22 (Examining Boards), Tex. Admin. Code § 465	**R-2, R-3, R-5**
V		**Superior**	
	V.A	Provider Contract Section 2	**M-2, P-1, P-2**
	V.B	Provider Contract Section 3	**M-1**
	V.C	Provider Contract Section 6	**R-4, R-5, R-6, B-2**
	V.D	Provider Contract Article VI	**R-1**
	V.E	Provider Manual Section 2	**P-3**
	V.F	Provider Manual Section 3	**M-1**
	V.G	Provider Manual Section 4	**M-2**
	V.H	Provider Manual Section 9	**B-1**
	V.I	Provider Manual Section 10	**P-1, B-3**
	V.J	Provider Manual Attachment B	**R-4**
	V.K	Provider Manual Attachment C	**R-4**
	V.L	Provider Manual Attachment N	**R-2, R-3**
	V.M	Provider Contract Provisions - Exhibit I	**B-3**
VI		**El Paso Health Criteria**	
	VI.A	Provider Manual Section 1	
	VI.B	Provider Manual Section 2	**P-1, P-2, P-3, R-1, R-4, R-5**
	VI.C	Provider Manual Section 3	**M-2**
	VI.D	Provider Manual Section 4	**M-1**
	VI.E	Provider Manual Section 9	**B-1**

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Criteria, Standards, and Guidance

The following specific state and federal Medicaid laws, regulations, rules, policies, and contractual requirements to be tested were agreed to by the HHSC-OIG in the approved audit test plan:

		Description	Tests
	VI.E	Provider Manual Section 12	**R-6, B-1, B-2, B-3**
	VI.F	Provider Contract Section 2	**P-3, R-1**
	VI.G	Provider Contract Section 3	**B-3**
	VI.H	Provider Contract Section 4	**M-1, B-3**
VII		**Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook**	
	VII.A	Section 2.2.14.2	**M-3**
	VII.B	Section 2.2.18.1	**M-3**
VIII		**The Children's Services Handbook**	
	VIII.A	Section 2.15	**M-3**
	VIII.B	Section 4.3.6	**M-3**
IX		**Telecommunication Services Handbook**	
	IX.A	Section 3 – Services, Benefits, Limitations, and Prior Authorizations	**R-7**
	IX.B	Section 3.1 – Patient Health Information Security	**R-7**
X		**The Medial and Nursing Specialists, Physicians, and Physician Assistants Handbook**	
	X.A	Section 9.2.40	**B-4**
XI		**The Radiology and Laboratory Services Handbook**	
	XI.A	Section 2.3	**B-4**
XIII		**Texas Medical Board Criteria**	
	XIII.A	Frequently Asked Questions (FAQs) Regarding Telemedicine During Texas Disaster Declaration for COVID-19 Pandemic	**R-2**