

Dental Treatment and Fraud Awareness



Ben Andersen – Lead Investigator
BCBSIL Special Investigations

Dr. Timothy Custer – Dental Director
BCBSIL



Experience. Wellness. Everywhere.SM

Experience. Wellness. Everywhere.

1

Dental Treatment and Fraud Awareness



Health Care Service Corporation (HCSC)




BlueCross BlueShield
of Illinois


BlueCross BlueShield
of New Mexico


BlueCross BlueShield
of Oklahoma


BlueCross BlueShield
of Texas

dearborn  national™

Experience. Wellness. Everywhere.

2

Dental Treatment and Fraud Awareness



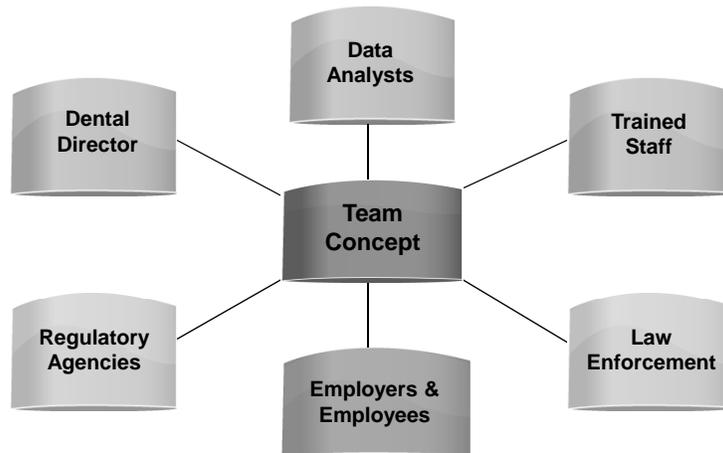
- Willfull submission
- False information
- Intent to gain



Experience. Wellness. Everywhere.

3

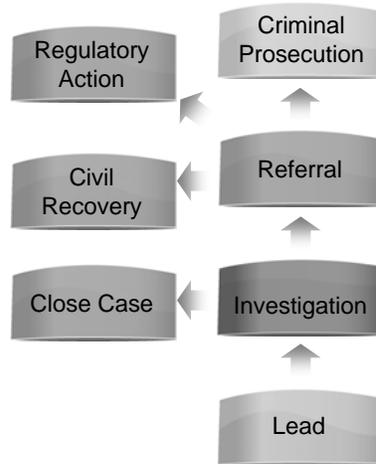
SID Team Concept



Experience. Wellness. Everywhere.

4

Investigative Model



Experience. Wellness. Everywhere.

5

Investigative Trivia #1



Nan



Byron McKeeby, D.D.S.

American Gothic, 1930

Experience. Wellness. Everywhere.

6

Dental Treatment and Fraud Awareness



Experience. Wellness. Everywhere.

7

Dental Treatment and Fraud Awareness



Department of Justice

ILLINOIS DENTAL MANAGEMENT COMPANY TO PAY \$3 MILLION TO SETTLE ALLEGATIONS OF IMPROPER BILLING, DENTIST REGISTRATION

...from August 1999 through October 2005, it falsely billed Illinois Medicaid for certain procedures: submitting claims for crown buildups, non-covered services, as restorations and claims for surgical extractions which were or should have been simple extractions

Experience. Wellness. Everywhere.

8

Dental Treatment and Fraud Awareness



May 2008

Dentist Pleads Guilty to Health Care Fraud

...May 17, 2004 through May 25, 2006, the dentist made \$94,098 in fraudulent claims for reimbursement of dental treatments and services to patients which were either never performed or which were different than the actual dental treatments and services performed.

Experience. Wellness. Everywhere.

9

Commonly Identified Fraud Schemes



- Performing unnecessary services
- Billing for services not provided
- Upcoding services
- Improper use of codes
- Identify theft
- Falsifying information

Experience. Wellness. Everywhere.

10

What is a Lead?



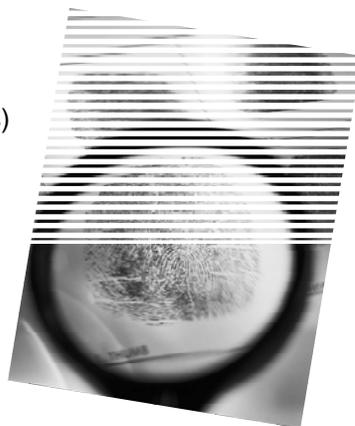
The initiation of every case is a “LEAD”

Internal

- Internal departments at BCBSIL
- Intelligence analysts (data analysis)

External

- Members and clients
- Law enforcement liaison
- Providers
- Other insurers



Experience. Wellness. Everywhere.

11

Employer



Employers &
Employees

Billing for services not provided

"Iris XXX is an LISD employee. In May, she saw a dentist in Nuevo Laredo. At that time she signed paperwork at the dentist's office and was reassured that he would file the claim for her services so that she would have the INSURANCE to pay for them.

Recently, she received a check \$1000. She was surprised because she had not received any services. The form was mailed and completed by the dentist and not the member."

Experience. Wellness. Everywhere.

12

Dentist



Employers & Employees

Identify theft

- On April 4, Warren received an explanation of benefits stating he had provided services to Joshunda on December 27, 2010. Warren said Joshunda is not his patient and he did not provide any services to her. Warren said someone obtained and fraudulently used his tax ID number.

BLUECROSS/BLUESHIELD PROVIDER ALERT FRAUD

CONFIDENTIAL MEMORANDUM
THE INFORMATION CONTAINED IN THIS REPORT SHOULD BE HANDLED AS CONFIDENTIAL

Initial Report	Revision History
Report Number: 8027-11-04-0011	Latest Revision: 2011-04-05 12:04 ET
Date/Time: 2011-04-05 12:37 ET	This Revision: 2011-04-05 12:04 ET
Received By: BAKJ	1 of 1
Source: Hdbw	QCSD/hauf

REPORT DETAILS

Report Narrative

Description of Fraud: On April 4, Warren received an explanation of benefits stating he had provided services to Joshunda on December 27, 2010. Warren said Joshunda is not his patient and he did not provide any services to her. Warren said someone obtained and fraudulently used his tax ID number.

Can you identify the persons or companies that are committing the fraud? No

How long has the fraud been going on? Since March 28, 2011.

Does anyone else know about the fraud? No

How did you learn about the fraud? Received the explanation of benefits stating he had provided services to Joshunda.

Do you have documentation concerning the fraud? No

Caller Information

Caller's Name: [Redacted]
 Caller's Address: Los Angeles, CA
 Caller's Telephone: [Redacted]

Patient Information

Patient Name: [Redacted]
 Patient Address: [Redacted]
 Patient Phone: [Redacted]
 Identification Number: [Redacted]

Date of Service: 2010-12-27 Amount Paid: 777.80 USD
 Insurance Type: Blue Cross Blue Shield Fraud Insurance: Blue Cross Blue Shield

Client agrees and understands that Central Compliance Services neither warrants, insures for, nor authenticates the integrity of the allegations provided in this report. Client agrees that it shall bear the sole responsibility for investigating or otherwise resolving these allegations and other information provided and is complying with all laws, rules and federal laws pertaining to the investigation and protection of such information, as well as the protection of all rights of any person or persons named in any writings.

Customer Service



Trained Staff (Customer Svc)

Falsifying information

“We have a DDS that has originally submitted for 7240, which is not covered on this policy. Should go to medical. After telling the provider office, they are now sending in corrected claims stating to change the code to 7230...”

Medical



**Trained Staff
(Medical Claims)**

Performing unnecessary services

“The billing by this provider is not typical of a dentist performing dental services. This dentist seems to have expanded his services outside the dentistry field and seems to be practicing medicine and psychology.”

Federal Agencies



**Law
Enforcement**

MAY-14-2009 15:40 FBI 217 757 3565 P.002



U.S. Department of Justice
Federal Bureau of Investigation

In Reply, Please Refer to
File No. 209B-SI-56926

900 E. Linton Ave.
Springfield, Illinois 62703
(217) 522-9675
May 14, 2009

Blue Cross/Blue Shield of Illinois
Attn: Ben Anderson
300 East Randolph Street
Chicago, IL 60601

RE: Dr. Frank [redacted] DDS

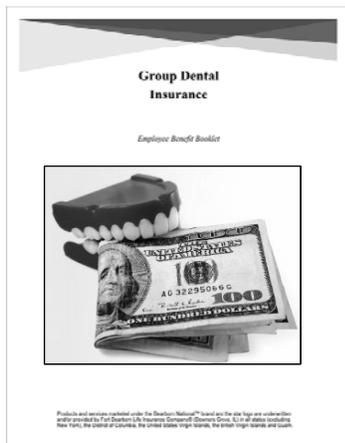
Dear Mr. Anderson:

The FBI, a law enforcement agency, is conducting an investigation of Dr. Frank [redacted] DDS, [redacted] Illinois [redacted] 2195. In furtherance of its investigation and pursuant to 45 C.F.R., Section 164.512(f), this Office is requesting that Blue Cross and Blue Shield of Illinois (BCBSIL) provide the following information:

Please provide any and all records and other information (written, electronic or otherwise) regarding claims submitted by or on behalf of Dr. [redacted] Jr., DDS, including, but not limited to, claim forms, cancelled checks issued in payment for claims, correspondence, proof of mailings received such as cancelled envelopes, and logs and/or transcripts of recorded telephone calls with Dr. [redacted]. Lastly, it is requested that BCBSIL provide any documentation regarding the training of Dr. [redacted] billing practices/matters.

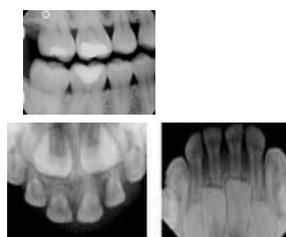
***Billing for services
not provided***

An Ounce of Prevention...



Radiographs

Full mouth, panorex, bitewings limited to ...
Other xrays as necessary for diagnosis



Occlusal x-rays

21

Experience. Wellness. Everywhere.

21

Performing unnecessary services

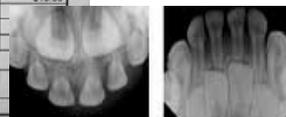


Radiographs

24. Procedure Date (MM/DD/YYYY)		25. Age (Years)	26. Teeth (Identify)	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1 7/11/2009						D0120	periodic oral evaluation	\$50.00
2 7/11/2009						D0274	Bitewings - Four Films	\$60.00
3 7/11/2009						D0240	Occlusal View X-ray	\$25.00
4 7/11/2009						D0240	Occlusal View X-ray	\$25.00
5 7/11/2009				04		D0220	Intraoral - Periapical - First Film	\$15.00
6 7/11/2009				14		D0230	Intraoral - Periapical - Each Add Film	\$15.00
7 7/11/2009				19		D0230	Intraoral - Periapical - Each Add Film	\$15.00
8 7/11/2009				30		D0230	Intraoral - Periapical - Each Add Film	\$15.00
9 7/11/2009						D1110	Prophylaxis - Adult	
10 7/11/2009				04		D2750	Crown-Porcelain Fused To High Noble Meta	



Occlusal X-Ray



Occlusal x-rays

MISSING TEETH		Permanent														Primary												32. Other Fee(s)
24. (Place an "X" on each missing tooth)		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	33. Total Fee
25. Remarks																												

Experience. Wellness. Everywhere.

22

Improper use of codes



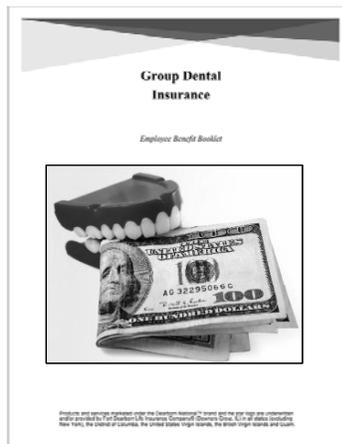
Root Canal Therapy – Post removal

Tooth # or letter	Surface	Description of service (procedure, progress, materials used, etc.)	Date service performed		Procedure number	Fee	For administrative use only
			Mo.	Year			
13		Post removal (not with endo)			D2955	350.00	
13		Retreat, prev RCT - bicuspid			D3347	1180.00	

RECEIVED
15 JUN 04 '07
BVL FSU

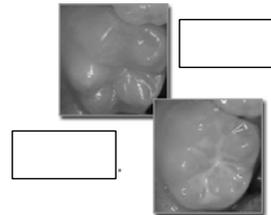
LR

An Ounce of Prevention...



Dental Sealants

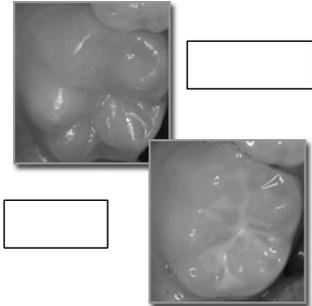
Limited to one per unrestored permanent molar for Participants up to age 16 .



Performing unnecessary services



Dental Sealants



Patient First Name	Patient Date of Birth	Patient Age	ADA Code	Tooth Number
JOHN		57	D1351	20
JOHN		55	D1351	12
JOHN		55	D1351	20
JOHN		55	D1351	21
JEANNA		53	D1351	04
JEANNA		53	D1351	05
JEANNA		53	D1351	13
JEANNA		53	D1351	15
JEANNA		53	D1351	16
JEANNA		53	D1351	18
JEANNA		53	D1351	19
JEANNA		53	D1351	20
JEANNA		53	D1351	21
JEANNA		53	D1351	28
JEANNA		53	D1351	29

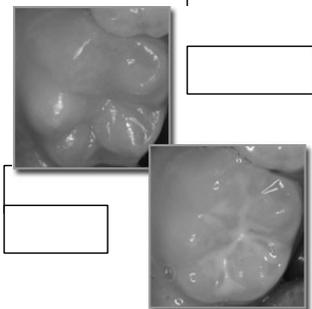
Experience. Wellness. Everywhere.

31

Billing for services not provided



Dental Sealants



Dental Claim Form
American Dental Association, 2006 01051900229

INSURANCE INFORMATION
 Type of Transaction (Check all that apply)
 Extension of dental benefits - DR Request for Preauthorization/Preauthorization
 Employee Fee For
 Other

INSURANCE MEMBER INFORMATION
 1 Name, Address, City, State, Zip Code
 Blue Cross and Blue Shield Of Texas
 2 Denial TX 75021
 3 Date of Birth (MM/DD/YYYY) 01/11/1973
 4 Gender M
 5 Plan/Group Number
 6 Employee Name
 7 Other Name
 8 Other Name

PATIENT INFORMATION
 9 Date of Birth (MM/DD/YYYY) 01/11/1973
 10 Gender M
 11 Subscriber Name (Last, First, Middle Initial, Suffix)
 12 Relationship to Primary Subscriber (Check appropriate box)
 13 Date of Birth (MM/DD/YYYY) 01/11/1973
 14 Plan/Group Number
 15 Relationship to Primary Subscriber (Check appropriate box)
 16 Other Name, Address, City, State, Zip Code
 17 Date of Birth (MM/DD/YYYY) 01/11/1973
 18 Gender M
 19 Patient Relationship (Check appropriate box)
 20 Other Name

RECORD OF SERVICES RENDERED

21 Procedure Code (ICD-9-CM)	22 Tooth Number or Location	23 Procedure Date	24 Description	25 Fee
		2003		
		1351	3	
		1351	14	
		1351	19	
		1351	30	

Additional Fees
 26 Periodic Fee
 27 Other Fee
 28 Total Fee \$515.00

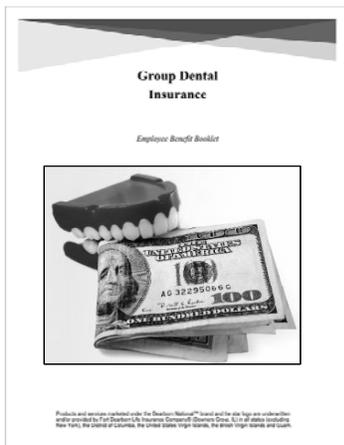
DECLARATION
 29 I hereby certify that the information provided on this form is true and correct to the best of my knowledge and belief.
 30 Signature (Print Name)
 31 Date

AUXILIARY CLAIM/TREATMENT INFORMATION
 32 Date of Transaction (MM/DD/YYYY)
 33 Date of Service (MM/DD/YYYY)
 34 Date of Payment (MM/DD/YYYY)
 35 Date of Expiration (MM/DD/YYYY)
 36 Date of Renewal (MM/DD/YYYY)
 37 Date of Termination (MM/DD/YYYY)
 38 Date of Suspension (MM/DD/YYYY)
 39 Date of Resumption (MM/DD/YYYY)
 40 Date of Cancellation (MM/DD/YYYY)
 41 Date of Reinstatement (MM/DD/YYYY)
 42 Date of Reinstatement (MM/DD/YYYY)
 43 Date of Reinstatement (MM/DD/YYYY)
 44 Date of Reinstatement (MM/DD/YYYY)
 45 Date of Reinstatement (MM/DD/YYYY)
 46 Date of Reinstatement (MM/DD/YYYY)
 47 Date of Reinstatement (MM/DD/YYYY)
 48 Date of Reinstatement (MM/DD/YYYY)
 49 Date of Reinstatement (MM/DD/YYYY)
 50 Date of Reinstatement (MM/DD/YYYY)

Experience. Wellness. Everywhere.

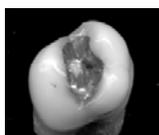
32

An Ounce of Prevention...



Restorative Services

The process of replacing part of a tooth that has been damaged by disease

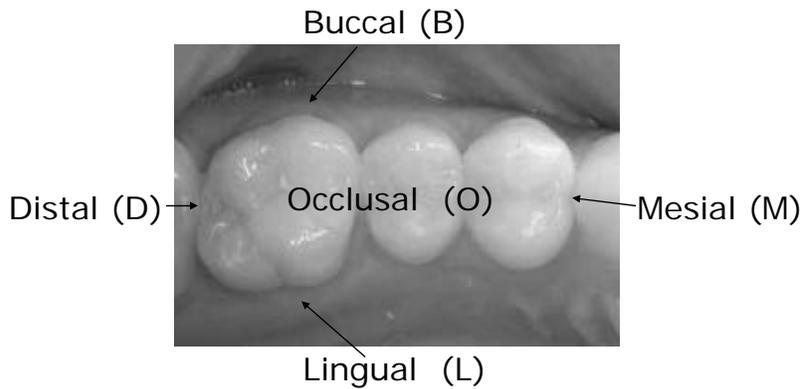


39

Experience. Wellness. Everywhere.

39

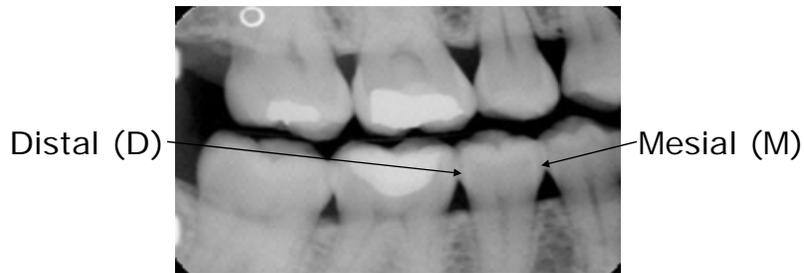
Restorative Services



Current Dental Terminology
Copyright By American Dental Association
Experience. Wellness. Everywhere.

40

Restorative Services

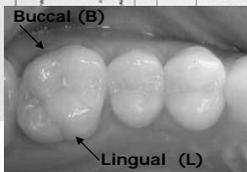


Current Dental Terminology
 Copyright By American Dental Association
 Experience. Wellness. Everywhere.

Services not provided ↔ Services Unnecessary



21. Patient name		22. Provider name		23. City, State, Zip		24. Date of birth		25. Sex		26. Race		27. First visit date		28. Place of treatment		29. Radiographs or models enclosed?		30. Is treatment result of occupational stress or injury?		31. Is treatment result of auto accident?		32. Other accident?		33. If prosthesis, is this initial placement?		34. Date of prior placement		35. Is treatment for orthodontics?		36. If service already commenced enter:		Date appliances placed		Max. treatment remaining																																					
D.D.S.		D.D.S.		CHICAGO, IL 60656										Office		X		X		X		X		X				X																																											
36. Identify missing teeth with "X"		37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.		Date service performed		Procedure number		Fee		For administrative use only																																																													
		<table border="1"> <tr> <th>Tooth #</th> <th>Surface</th> <th>Description of service (including crown, inlay/onlay, materials used, etc.)</th> <th>Date service performed</th> <th>Procedure number</th> <th>Fee</th> </tr> <tr> <td>14</td> <td>B</td> <td>Resin composite-1s, posterior</td> <td>02 17 2005</td> <td>D2391</td> <td>180.00</td> </tr> <tr> <td>19</td> <td>B</td> <td>Resin composite-1s, posterior</td> <td>02 17 2005</td> <td>D2391</td> <td>180.00</td> </tr> <tr> <td>C</td> <td>L</td> <td>Resin-one surface, anterior</td> <td>02 17 2005</td> <td>D2330</td> <td>180.00</td> </tr> <tr> <td>H</td> <td>L</td> <td>Resin-one surface, anterior</td> <td>02 17 2005</td> <td>D2330</td> <td>180.00</td> </tr> <tr> <td>K</td> <td>B</td> <td>Resin composite-1s, posterior</td> <td>02 17 2005</td> <td>D2391</td> <td>180.00</td> </tr> </table>		Tooth #	Surface	Description of service (including crown, inlay/onlay, materials used, etc.)	Date service performed	Procedure number	Fee	14	B	Resin composite-1s, posterior	02 17 2005	D2391	180.00	19	B	Resin composite-1s, posterior	02 17 2005	D2391	180.00	C	L	Resin-one surface, anterior	02 17 2005	D2330	180.00	H	L	Resin-one surface, anterior	02 17 2005	D2330	180.00	K	B	Resin composite-1s, posterior	02 17 2005	D2391	180.00																																
Tooth #	Surface	Description of service (including crown, inlay/onlay, materials used, etc.)	Date service performed	Procedure number	Fee																																																																		
14	B	Resin composite-1s, posterior	02 17 2005	D2391	180.00																																																																		
19	B	Resin composite-1s, posterior	02 17 2005	D2391	180.00																																																																		
C	L	Resin-one surface, anterior	02 17 2005	D2330	180.00																																																																		
H	L	Resin-one surface, anterior	02 17 2005	D2330	180.00																																																																		
K	B	Resin composite-1s, posterior	02 17 2005	D2391	180.00																																																																		



RECEIVED

Services not provided ↔ Services Unnecessary



Blue Cross Blue Shield of Illinois Dental or Dental Entity
 D.D.S.
 CHICAGO, IL 60656

30. Is treatment result of occupational illness or injury? No Yes
 31. Is treatment result of auto accident? No Yes
 32. Other accident? No Yes

33. If prosthesis, is this initial placement? No Yes
 34. Date of prior placement

35. Is treatment for orthodontics? No Yes

36. Identify missing teeth with "X"

37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.

Tooth #	Surface	Description of service (including x-rays, prosthesis, materials used, etc.)	Date service performed (Mo, Day, Year)	Procedure number	Fee	For administrative use only
22	MDF	Resin-three surfaces, anterior	02 11 2005	D2332	260.00	
23	MDF	Resin-three surfaces, anterior	02 11 2005	D2332	260.00	
24	MDF	Resin-three surfaces, anterior	02 11 2005	D2332	260.00	
25	MDF	Resin-three surfaces, anterior	02 11 2005	D2332	260.00	
26	MDF	Resin-three surfaces, anterior	02 11 2005	D2332	260.00	

RECEIVED
053 -

Facial (F)

Experience. Wellness. Everywhere.

43

Services not provided ↔ Services Unnecessary



Blue Cross Blue Shield of Illinois Dental or Dental Entity
 D.D.S.
 CHICAGO, IL 60656

30. Is treatment result of occupational illness or injury? No Yes
 31. Is treatment result of auto accident? No Yes
 32. Other accident? No Yes

33. If prosthesis, is this initial placement? No Yes
 34. Date of prior placement

35. Is treatment for orthodontics? No Yes

36. Identify missing teeth with "X"

37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.

Tooth #	Surface	Description of service (including x-rays, prosthesis, materials used, etc.)	Date service performed (Mo, Day, Year)	Procedure number	Fee	For administrative use only
22	MDF	Resin-three surfaces, anterior	02 11 2005	D2332	260.00	
23	MDF	Resin-three surfaces, anterior	02 11 2005	D2332	260.00	
24	MDF	Resin-three surfaces, anterior	02 11 2005	D2332	260.00	
25	MDF	Resin-three surfaces, anterior	02 11 2005	D2332	260.00	
26	MDF	Resin-three surfaces, anterior	02 11 2005	D2332	260.00	
4	MDB	Resin composite-3s, posterior	04 05 2			
5	MDB	Resin composite-3s, posterior	04 05 2			
6	MDF	Resin-three surfaces, anterior	04 05 2			
7	MDF	Resin-three surfaces, anterior	04 05 2			
8	MDF	Resin-three surfaces, anterior	04 05 2			
9	MDF	Resin-three surfaces, anterior	04 05 2			

RECEIVED
053 -

Facial (F)

Facial (F)

Experience. Wellness. Everywhere.

44

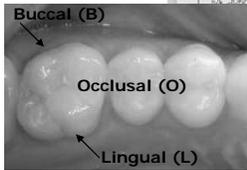
Upcoding ↔ Services Unnecessary



21. Date of Birth (MM/DD/YYYY) 10/10/1969
 22. Gender M F
 23. Patient ID/Account # (Assigned by Dentist) 28652

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
06/24/2010					D0150	Comprehensive Oral Exam	60.00
06/24/2010					D0330	Panoramic Film	100.00
06/24/2010			3	OL	D2392	Resin 2 surf. post	125.00
06/24/2010			14	OL	D2392	Resin 2 surf. post	125.00
06/24/2010			31	OL	D2392	Resin 2 surf. post	125.00
06/24/2010			18	OL	D2392	Resin 2 surf. post	125.00
06/24/2010			19	OL	D2392	Resin 2 surf. post	125.00



Experience. Wellness. Everywhere.

47

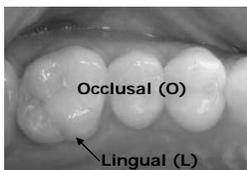
Upcoding ↔ Services Unnecessary



21. Date of Birth (MM/DD/YYYY) 10/10/1969
 22. Gender M F
 23. Patient ID/Account # (Assigned by Dentist) 28652

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
06/24/2010					D0150	Comprehensive Oral Exam	60.00
06/24/2010					D0330	Panoramic Film	100.00
06/24/2010			3	OL	D2392	Resin 2 surf. post	125.00
06/24/2010			14	OL	D2392	Resin 2 surf. post	125.00
06/24/2010			31	OL	D2392	Resin 2 surf. post	125.00
06/24/2010			18	OL	D2392	Resin 2 surf. post	125.00
06/24/2010			19	OL	D2392	Resin 2 surf. post	125.00



Experience. Wellness. Everywhere.

48

Upcoding



Services not provided



Form 1: Patient Information and History

Form 2: Dental History and Treatment Plan

Form 3: Insurance Information

Form 4: Radiographs (X-rays)

Form 5: Treatment Plan Table

Item	Description of service (including procedure, material used, etc.)	Date service performed	Procedure number	Fee	Fee attributable to insurance only
3	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
4	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
5	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
12	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
13	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
14	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
15	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
16	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
17	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
18	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
19	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
20	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
21	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
22	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
23	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
24	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
25	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
26	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	

Upcoding



Services not provided



Form 1: Patient Information and History

Form 2: Dental History and Treatment Plan

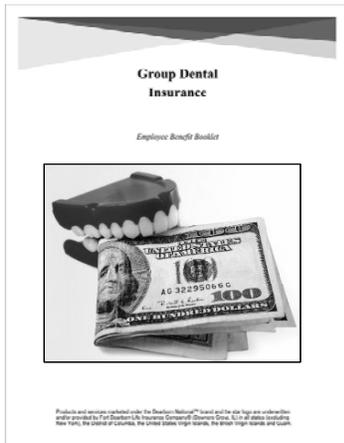
Form 3: Insurance Information

Form 4: Radiographs (X-rays)

Form 5: Treatment Plan Table

Item	Description of service (including procedure, material used, etc.)	Date service performed	Procedure number	Fee	Fee attributable to insurance only
3	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
4	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
5	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
12	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
13	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
14	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
15	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
16	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
17	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
18	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
19	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
20	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
21	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
22	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
23	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
24	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
25	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	
26	ABALCON 4 SURFACE	4/7/11	D 2161	400.00	

An Ounce of Prevention...



Oral Surgery

Surgical tooth extractions
Other necessary surgical procedures



55

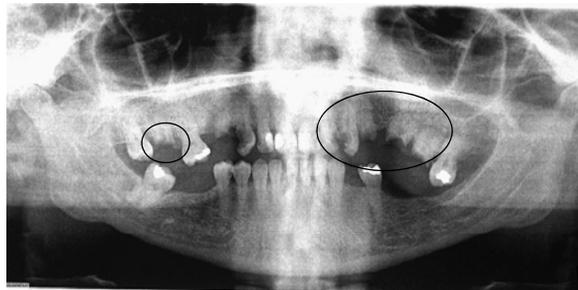
Experience. Wellness. Everywhere.

55

Upcoding Services



Oral Surgery

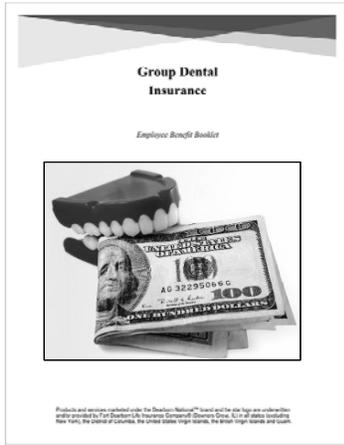


10	Surgical extraction	6511	750	240
11	Surgical extraction	6512	750	240
12	Removal residual roots	6511	750	240
13	Removal residual roots	6512	750	240
14	Removal residual roots	6511	750	240
15	Removal residual roots	6512	750	240

Experience. Wellness. Everywhere.

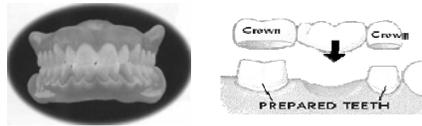
56

An Ounce of Prevention...



Prosthodontic Services

Dental services that restore missing teeth. Covered Services include bridges, partial dentures and complete dentures.



Falsifying records



EXTRACTIONS - ROUTINE

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Handwritten: FU

EXTRACTIONS - SURGICAL

LINE NO.	DATE	DESCRIPTION OF WORK PROPOSED OR COMPLETED	DR. FEE
1	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
2	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
3	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
4	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
5	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
6	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
7	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
8	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
9	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
10	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
11	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
12	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
13	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
14	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
15	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
16	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
17	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
18	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
19	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
20	1/2/10	EXTRACTION OF LOWER PERIODONTAL	

EXTRACTIONS - ROUTINE

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

EXTRACTIONS - SURGICAL

LINE NO.	DATE	DESCRIPTION OF WORK PROPOSED OR COMPLETED	DR. FEE
1	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
2	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
3	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
4	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
5	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
6	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
7	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
8	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
9	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
10	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
11	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
12	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
13	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
14	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
15	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
16	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
17	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
18	1/2/10	EXTRACTION OF LOWER PERIODONTAL	
19	1/2/10	EXTRACTION OF UPPER PERIODONTAL	
20	1/2/10	EXTRACTION OF LOWER PERIODONTAL	

Falsifying records



BlueCross BlueShield of Illinois

<p>EXTRACTIONS - ROUTINE</p> <p>EXTRACTIONS - SURGICAL</p>												<p>EXTRACTIONS - ROUTINE</p> <p>EXTRACTIONS - SURGICAL</p>											
<p>PROGRESS COMPLETE FOR ANY RECEIPT AND CURRENTLY HAS A PROVISION:</p> <p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>												<p>PROGRESS COMPLETE FOR ANY RECEIPT AND CURRENTLY HAS A PROVISION:</p> <p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>											
<p>DESCRIPTION OF WORK PROPOSED OR COMPLETED</p> <p>1. <i>Exam</i></p> <p>2. <i>Exam</i></p> <p>3. <i>Exam</i></p> <p>4. <i>Exam</i></p> <p>5. <i>Clindamycin + premed 1st abx</i></p> <p>6. <i>Clindamycin + premed 1st abx</i></p> <p>7. <i>Clindamycin + premed 1st abx</i></p> <p>8. <i>Clindamycin + premed 1st abx</i></p> <p>9. <i>Clindamycin + premed 1st abx</i></p> <p>10. <i>Clindamycin + premed 1st abx</i></p> <p>11. <i>Clindamycin + premed 1st abx</i></p> <p>12. <i>Clindamycin + premed 1st abx</i></p> <p>13. <i>Clindamycin + premed 1st abx</i></p> <p>14. <i>Clindamycin + premed 1st abx</i></p> <p>15. <i>Clindamycin + premed 1st abx</i></p> <p>16. <i>Clindamycin + premed 1st abx</i></p>												<p>DESCRIPTION OF WORK PROPOSED OR COMPLETED</p> <p>1. <i>Exam</i></p> <p>2. <i>Exam</i></p> <p>3. <i>Exam</i></p> <p>4. <i>Exam</i></p> <p>5. <i>Clindamycin + premed 1st abx</i></p> <p>6. <i>Clindamycin + premed 1st abx</i></p> <p>7. <i>Clindamycin + premed 1st abx</i></p> <p>8. <i>Clindamycin + premed 1st abx</i></p> <p>9. <i>Clindamycin + premed 1st abx</i></p> <p>10. <i>Clindamycin + premed 1st abx</i></p> <p>11. <i>Clindamycin + premed 1st abx</i></p> <p>12. <i>Clindamycin + premed 1st abx</i></p> <p>13. <i>Clindamycin + premed 1st abx</i></p> <p>14. <i>Clindamycin + premed 1st abx</i></p> <p>15. <i>Clindamycin + premed 1st abx</i></p> <p>16. <i>Clindamycin + premed 1st abx</i></p>											
<p>DR. FEE</p>												<p>DR. FEE</p>											
<p>Private Case Total Amt. Revised Amt.</p>												<p>Private Case Total Amt. Revised Amt.</p>											

Falsifying records



BlueCross BlueShield of Illinois

<p>EXTRACTIONS - ROUTINE</p> <p>EXTRACTIONS - SURGICAL</p>												<p>EXTRACTIONS - ROUTINE</p> <p>EXTRACTIONS - SURGICAL</p>											
<p>PROGRESS COMPLETE FOR ANY RECEIPT AND CURRENTLY HAS A PROVISION:</p> <p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>												<p>PROGRESS COMPLETE FOR ANY RECEIPT AND CURRENTLY HAS A PROVISION:</p> <p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>											
<p>DESCRIPTION OF WORK PROPOSED OR COMPLETED</p> <p>1. <i>Exam</i></p> <p>2. <i>Exam</i></p> <p>3. <i>Exam</i></p> <p>4. <i>Exam</i></p> <p>5. <i>Clindamycin + premed 1st abx</i></p> <p>6. <i>Clindamycin + premed 1st abx</i></p> <p>7. <i>Clindamycin + premed 1st abx</i></p> <p>8. <i>Clindamycin + premed 1st abx</i></p> <p>9. <i>Clindamycin + premed 1st abx</i></p> <p>10. <i>Clindamycin + premed 1st abx</i></p> <p>11. <i>Clindamycin + premed 1st abx</i></p> <p>12. <i>Clindamycin + premed 1st abx</i></p> <p>13. <i>Clindamycin + premed 1st abx</i></p> <p>14. <i>Clindamycin + premed 1st abx</i></p> <p>15. <i>Clindamycin + premed 1st abx</i></p> <p>16. <i>Clindamycin + premed 1st abx</i></p>												<p>DESCRIPTION OF WORK PROPOSED OR COMPLETED</p> <p>1. <i>Exam</i></p> <p>2. <i>Exam</i></p> <p>3. <i>Exam</i></p> <p>4. <i>Exam</i></p> <p>5. <i>Clindamycin + premed 1st abx</i></p> <p>6. <i>Clindamycin + premed 1st abx</i></p> <p>7. <i>Clindamycin + premed 1st abx</i></p> <p>8. <i>Clindamycin + premed 1st abx</i></p> <p>9. <i>Clindamycin + premed 1st abx</i></p> <p>10. <i>Clindamycin + premed 1st abx</i></p> <p>11. <i>Clindamycin + premed 1st abx</i></p> <p>12. <i>Clindamycin + premed 1st abx</i></p> <p>13. <i>Clindamycin + premed 1st abx</i></p> <p>14. <i>Clindamycin + premed 1st abx</i></p> <p>15. <i>Clindamycin + premed 1st abx</i></p> <p>16. <i>Clindamycin + premed 1st abx</i></p>											
<p>DR. FEE</p>												<p>DR. FEE</p>											
<p>Private Case Total Amt. Revised Amt.</p>												<p>Private Case Total Amt. Revised Amt.</p>											

Falsifying records



13		Take 2 qon unfinished			
14	4-26-10	2 Caps Vidoz 70 u/1:10mg			
15		5 1-F COMP ETCH (ROM)			
16		8 -F			
17		9 -F			
18		11 -F			
19					
20					
21					

	Private Case	Treatment Plan	Payment Plan
13		Take 2 qon unfinished	
14	4-26-10	2 Caps Vidoz 70 u/1:10mg	
15		5 1-F COMP ETCH (ROM)	
16		8 -F	
17		9 -F	
18		11 -F	
19			
20			
21			

Experience. Wellness. Everywhere.

63

An Ounce of Prevention...



Group Dental Insurance

Employee Benefit Booklet

Products and services provided under the Group Dental Insurance Plan are not for sale and are not intended to be sold. This document is not a contract. It is provided for informational purposes only. For more information, please contact your agent or the plan administrator. © 2010 BlueCross BlueShield of Illinois. All rights reserved.

Periodontal Services

- Scaling and root planning
- Full mouth debridement



64

Experience. Wellness. Everywhere.

64

Billing for services not provided



Periodontal Services

RECORD OF SERVICES PROVIDED		21. Date of Birth (MM/DD/YYYY)		22. Gender		23. Patient ID/Account # (Assigned by Dentist)	
		05/31/1972		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		012301	
24. Procedure Date (MM/DD/YYYY)	25. Anesthesia Code	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
08/19/2011	JP				D0120	Periodic oral evaluation	48.00
08/19/2011	JP				D0274	Bitewings-four films	59.00
08/19/2011	JP				D0431	Adjunctive Pre Diag Test	65.00
08/19/2011	JP	15			D4381	Locally Applied Antibiotic	37.00
08/19/2011	JP	16			D4381	Locally Applied Antibiotic	37.00
							263.00
							263.00
							263.00
							263.00
							263.00
							- 84.00
				Primary Insurance Payment			
MISSING TEETH INFORMATION							
24. (Place an 'X' on each missing tooth)							
	X						
	X						
25. Remarks: <i>no oral yermCAD a him</i>							
							23. Total Fee
							1298.00

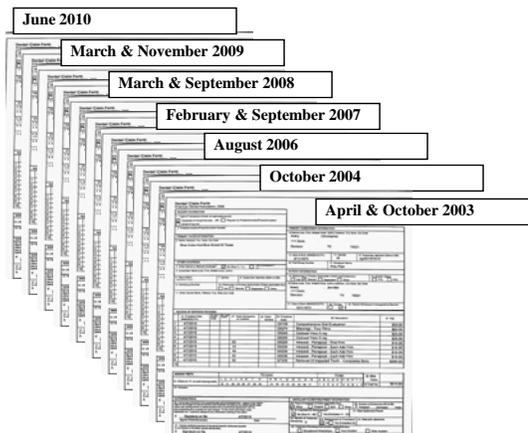
Experience. Wellness. Everywhere.

65

Billing for services not provided



Periodontal Services



Experience. Wellness. Everywhere.

66

Falsifying records



Chart-It, Inc.
Sample Report
01327060975
Periodontal Exam Tables

Name: [Redacted] Edmona Pat# 2020 Appointment Date: 6-22-10
 Prov: [Redacted] Date Signed: 6-22-10
 Provider's Signature: *CPJ*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket	4	2	4	7	4	6	4	4	4	4	4	4	4	4	4	4
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Furcation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	4	2	4	7	4	6	4	4	4	4	4	4	4	4	4	4
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Pocket	4	2	4	7	4	6	4	4	4	4	4	4	4	4	4	4
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Furcation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	4	2	4	7	4	6	4	4	4	4	4	4	4	4	4	4
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Mobility: 1 % 1% 1

Falsifying records



Chart-It, Inc.
Sample Report
01327060883
Periodontal Exam Tables

Name: [Redacted] MARIA Pat# 2020 Appointment Date: 4-9-10
 Prov: [Redacted] Date Signed: 4-12-10
 Provider's Signature: *CPJ*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Furcation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Pocket	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Furcation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Mobility: 1 % 1% 1

Falsifying records



Chart-It, Inc.
Sample Report
Periodontal Exam Tables

Name: James Pat# 2020 Appointment Date: 5-3-10
 Provider Signature: *[Signature]* Date Signed: 5-3-10

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket	8	7	5	7	4	5	8	5	5	5	5	5	5	5	5	5
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Function	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pocket	7	4	7	6	7	6	6	5	4	5	4	6	4	5	5	5
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Function	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mobility									1	%	%	1				

	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18
Pocket	8	7	7	6	7	6	6	5	5	5	5	5	5	5	5
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Function	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pocket	7	4	7	6	7	6	6	5	4	5	4	6	4	5	5
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Function	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mobility									1	%	%	1			

71

Falsifying records



Chart-It, Inc. 01252002959
Sample Report
Periodontal Exam Tables

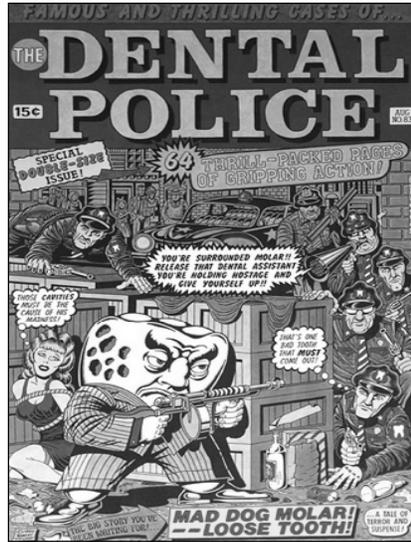
Name: JUAN Pat# 2020 Appointment Date: 4-26-10
 Provider Signature: *[Signature]* Date Signed: 4-26-10

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket	8	7	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Function	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pocket	7	4	7	6	7	6	6	5	4	5	4	6	4	5	5	5
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Function	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mobility									1	%	%	1				

	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18
Pocket	8	7	6	7	6	7	6	6	5	5	5	5	5	5	5
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Function	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pocket	7	4	7	6	7	6	6	5	4	5	4	6	4	5	5
Bleeding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suppuration	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FCM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MGJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Function	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attachment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attach Chg	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mobility									1	%	%	1			

72

Data Intelligence in Dental Fraud



Identify aberrant billing

Examine billing data

Prepayment review of claims

Wellness. Everywhere.

73

Identify billing trends



Composite Ranking

RADIOGRAPHS	PERIODONTICS	CROWNS	RESTORATIVE	ORAL SURGERY	DOLLARS	MISCELLANEOUS
FBT026 Average # Radiographs / Patient	FBT013 Average # of Gross Debridements / Routine Prophyl	FBZSB7 Average # Crowns / Patient	FBZSC7 Average # Resins / Patient	FBT003 Average # Low Surgical per Simple	FBG003 Total Dollars Charged	FBT086 % Procedures with Palliative Care
FBT028 % Patients having Panorex	FBT056 Average # Scaling Procedures / Patient	FBT065 % Crown Procedures w/ Buildups	FBT017 % Restorations having Pulp Caps	FBT004 Average # High Surgical per Lesser Surgical	FBG002 Average Dollars Charged / Patient	FBG060 Average # Procedures / Patient
	FBT034 Average # of Patients under 16 receiving scaling	FBT041 # Inlay / Onlay Procedures	FBT008 % Restorations having Pulp Tests			FBG006 Average # Procedures / Visit
			FBT001 Average # Pulp			FBG020 Total # of

Experience. Wellness. Everywhere.

74

Proactive Data Analysis



Bill TIN	Ave Amalgam	Ave Surgical	Ave Radiographs	Ave Crowns	Ave Procedures	Ave Proc per Visit
12345678	18.00	149.00	7.84	1.22	16.20	7.39
12345678	12.00	65.00	6.00	0.93	14.54	6.40
12345678	10.00	57.00	5.76	0.93	12.69	6.27
12345678	10.00	50.50	5.59	0.79	12.51	5.95
12345678	10.00	42.20	4.79	0.75	12.00	5.94
12345678	9.00	40.00	4.74	0.73	11.87	5.90
12345678	8.00	38.33	4.64	0.71	11.78	5.84
12345678	7.00	37.00	4.62	0.70	11.54	5.61
12345678	6.50	37.00	4.58	0.69	11.43	5.47
12345678	6.50	35.00	4.49	0.69	11.28	5.39
12345678	6.20	35.00	4.43	0.67	11.23	5.37
12345678	6.00	33.00	4.32	0.65	11.21	5.23
12345678	5.50	32.33	4.31	0.65	11.13	5.18
12345678	5.20	30.00	4.27	0.60	11.02	4.92
12345678	5.00	29.00	4.11	0.59	11.00	4.90
12345678	5.00	28.75	3.98	0.59	10.64	4.89
12345678	4.50	24.00	3.90	0.56	10.58	4.88
12345678	4.33	24.00	3.89	0.56	10.51	4.87
12345678	4.00	23.40	3.78	0.56	10.43	4.85
12345678	4.00	22.67	3.75	0.55	10.39	4.84
12345678	4.00	22.33	3.73	0.54	10.35	4.81
12345678	3.67	22.00	3.72	0.53	10.34	4.80
12345678	3.60	21.00	3.67	0.53	10.34	4.75
12345678	3.56	21.00	3.66	0.52	10.33	4.75
12345678	3.00	20.43	3.61	0.51	10.30	4.75

Experience. Wellness. Everywhere.

75



Health Care Services Corporation

Provider Report Card

Ordered by Provider ID

PE010

Peer Group:

Value Set:

Model:

Profile:

Provider:

Element	Description	Rank	Score	Value	Minimum	Median	Maximum	Weight
	Composite Score	1	598	8	1.00	29.66	598.32	0
BGH103	E&M Group	1	1,000	0.00	0.00	1,000.00	0	5
FB0006	Avg # of Pcs/Visit	389	1,000	7.33	1.00	2.39	44.00	5
BGH005	Dollar Group	2,227	1	1.00	1.00	722.22	5	5
FB0003	Total \$ Charged	6,148	1	6,663.00	5.00	1,133.00	1,162,172.00	5
BGH121	Patient Group	1,100	594	1.00	1.00	601.07	5	5
FB0002	Avg \$ Charged/Patient	1,100	988	2,221.00	5.00	381.50	39,555.00	5
FB0019	Total # of Patients	17,195	1	3.00	1.00	2.00	1,999.00	1
FB1034	Avg # Preventive/ Pat Under 16	1	0	0.00	0.00	0.00	0.00	5
BGH122	Procedure Group	13	453	0.00	0.00	1.00	672.95	5
FB0040	Avg # of Procedures/Patient	9	1,000	36.67	1.00	4.60	64.00	5
FB1065	% Crown Pcs w/ Core Buildup Pk	492	12	200.00	0.00	0.00	3,200.00	5
FB2587	Avg # of crowns/Patient	1	0	0.00	0.00	0.00	0.00	5
FB25C7	Avg # of resin restorations/Patient	1	0	0.00	0.00	0.00	0.00	5
BGH124	General Volume	61	801	0.00	0.00	5.47	801.59	5
FB1003	Avg # Low Surg Extr per Simple	1	0	0.00	0.00	0.00	0.00	5
FB1026	Avg # Single Film Rad / Patient	5	1,000	21.67	0.00	0.75	56.00	5
FB1056	Avg # Root Filing Pcs/Patient	1,005	1,000	1.33	0.00	0.00	10.00	5
BGH145	Suspicious	1	0	0.00	0.00	0.00	0.00	5
FB1048	# Suspect Exams within 5 Days of PCDs	1	0	0.00	0.00	0.00	0.00	5

Experience. Wellness. Everywhere.

76

Billing trend: Case #1



Composite Ranking

Endodontic Therapy



RESTORATIVE	ORAL SURGERY	DOLLARS	MISCELLANEOUS
FBZSC7 Average # Resins / Patient	FBT003 Average # Low Surgical per Simple	FBG003 Total Dollars Charged	FBT086 % Procedures with Palliative Care
FBT017 % Restorations having Pulp Caps	FBT004 Average # High Surgical per Lesser Surgical	FBG002 Average Dollars Charged / Patient	FBG060 Average # Procedures / Patient
FBT008 % Restorations having Pulp Tests			FBG006 Average # Procedures / Visit
FBT001 Average # Pulp			FBG020 Total # of

Experience. Wellness. Everywhere.

77

Billing trend: Case #1



Audit Request



VIA CERTIFIED MAIL
April 27, 2009

D.D.S.
[Redacted]

Chicago, IL 60611

Re: Dental Records Request

Dear Dr. M [Redacted]

Periodically, Blue Cross and Blue Shield of Illinois (BCBSIL), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, selects claims for further review. This letter is to inform you that a sample of the claims you previously submitted to BCBSIL, have been selected for review.

For each patient listed below, you are requested to provide complete dental records to BCBSIL within 10 days from the date of this letter. "Complete dental records" means any and all records from the start of care through the present, including treatment plans, treatment notes and pre-operative/working/post-operative final fill radiographs associated with all root canal therapy. Please make sure that all records are properly labeled and dated, including the mounting of radiographs. The records should be delivered to the following address: BCBSIL, 200 F. Randolph Chicago, IL 60601 c/o: Ben Anderson 12th floor.

Insurance ID	Last Name	First Name
1	283	DOMENIK
2	283	DOMENIK
3	063	DOMENIKOWSKI
4	063	DOMENIKOWSKI
5	925	GILODE
6	925	GILODE
7	237	GINIADEN
8	237	GINIADEN
9	547	KOLONIZI
10	958	ORZECHOWSKI
11	958	ORZECHOWSKI
12	814	SABECKI
13	865	SOCKO

Please note that only legible dental records will be accepted for a review. If the original treatment notes are not legible, please also submit a typed version of the treatment notes.

If you have any questions, please feel free to call Ben Anderson at (312) 653-8826. Your cooperation in this matter is most appreciated.

78

Billing trend: Case #1



[Redacted] D.D.S.
[Redacted]
CHICAGO, IL 60641
TEL. 1773 4286-5333

Audit Response

May 7, 2009

To whom it Concerns

Due to reduce hours, our dental clinic no longer can accept patients with dental insurance.

including Bluecross Blue Shield of Illinois.

Please disregard any claims that were sent to you from this clinic. Thank You for Your service

Sincerely Dr. P.

[Redacted]

P.S. Our clinic will be closed until July 2009.

Restitution Check



[Redacted] DDS LTD 4656
CHICAGO, IL 60641-4127

PAY TO THE ORDER OF Blue Cross and Blue Shield of IL \$ 121,156.56
one hundred twenty one thousand one hundred fifty six 56/100 DOLLARS

DATE 8-13-09 70-411-719

Five Star Service Guaranteed

FOR [Redacted]

Billing trend: Case #1



HW-29-2009 13:45 DPR CRS 312 814 3134 P.01/01



Illinois Department of Financial and Professional Regulation
Division of Professional Regulation

PAT QUINN
Governor

MICHAEL T. MICHAITH
Acting Secretary
DANIEL E. ELUTHARDT
Director
Division of Professional Regulation

**Billing for services
not provided**

May 15, 2009

Dental Network of America
Attn: Dr. Tim Custer
Two Trans Am Plaza Drive
Suite 500
Oakbrook Terrace, Illinois 60181

Re: Request for information

Dear Dr. Custer:

The Department is conducting investigations of two individual dentists at this time. In furtherance of this investigation and pursuant to 45 C.F.R. ss 164.512 (f), this Office is requesting that DNOA provide the following information:

Please provide any and all records and claim/payment information related to those submitted by

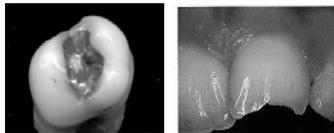
If other information is needed, this Office will submit a supplemental request in writing. In support of this request, this Office hereby states that:

Billing trend: Case #2a



Composite Ranking

Restorative Services



RESTORATIVE

ORAL SURGERY

DOLLARS

MISCELLANEOUS

FBZSG7
Average # Resins / Patient

FBT003
Average # Low Surgical per Simple

FBG003
Total Dollars Charged

FBT086
% Procedures with Palliative Care

FBT017
% Restorations having Pulp Caps

FBT004
Average # High Surgical per Lesser Surgical

FBG002
Average Dollars Charged / Patient

FBG060
Average # Procedures / Patient

FBT008
% Restorations having Pulp Tests

FBG006
Average # Procedures / Visit

FBT001
Average # Pulp

FBG020
Total # of

Billing trend: Case #2



24 Procedure Date (MM/DD/YYYY)		25 Area of Oral Cavity	26 Tooth System	27 Tooth Number(s) or Letter(s)	28 Tooth Surface	29 Procedure Code	30 Description	31 Fee
21 Date of Birth (MM/DD/YYYY) 05/11/1998 22 Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F 23 Patient ID/Account # (Assigned by Denist) FA0024								
RECORD OF SERVICES PROVIDED								
1	02/21/2009		JP			D0120	Periodic oral evaluation	60.00
2	02/21/2009		JP			D1120	Prophylaxis-child	120.00
3	02/21/2009		JP			D1203	Fluoride w/o prophylaxis-child	40.00
4	02/21/2009		JP	14	OLB	D2393	Resin composite-3s, posterior	280.00
5	02/21/2009		JP	30	OLB	D2393	Resin composite-3s, posterior	280.00
6	02/21/2009		JP	J	OLB	D2393	Resin composite-3s, posterior	280.00
7	02/21/2009		JP	K	OLB	D2393	Resin composite-3s, posterior	280.00
8	02/21/2009		JP	L	OLB	D2393	Resin composite-3s, posterior	280.00
9	02/21/2009		JP					
10								

24 Procedure Date (MM/DD/YYYY)		25 Area of Oral Cavity	26 Tooth System	27 Tooth Number(s) or Letter(s)	28 Tooth Surface	29 Procedure Code	30 Description	31 Fee
21 Date of Birth (MM/DD/YYYY) 03/14/2002 22 Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F 23 Patient ID/Account # (Assigned by Denist) KH0010								
RECORD OF SERVICES PROVIDED								
1	09/09/2008		JP	3	OLB	D2393	Resin composite-3s, posterior	280.00
2	09/09/2008		JP	14	OLB	D2393	Resin composite-3s, posterior	280.00
3	09/09/2008		JP	19	OLB	D2393	Resin composite-3s, posterior	280.00
4	09/09/2008		JP	30	OLB	D2393	Resin composite-3s, posterior	280.00
5								
6								
7								

Experience. Wellness. Everywhere.

83

Billing trend: Case #2



24 Procedure Date (MM/DD/YYYY)		25 Area of Oral Cavity	26 Tooth System	27 Tooth Number(s) or Letter(s)	28 Tooth Surface	29 Procedure Code	30 Description	31 Fee
RECORD OF SERVICES PROVIDED								
1	12/27/2008		JP	19		D7140	Extract,erupted th/exposed rt	300.00
2	12/27/2008		JP	30		D2954	Prelab postScore in add to crn	350.00
3	12/28/2008		JP	17	MOLB	D2394	Resin composite-4+s, posterior	350.00
4	12/30/2008		JP	18	MODL	D2394	Resin composite-4+s, posterior	350.00
5	12/30/2008		JP	20	ODL	D2393	Resin composite-3s, posterior	280.00
6	12/30/2008		JP	21	OL	D2392	Resin composite-2s, posterior	240.00

24 Procedure Date (MM/DD/YYYY)		25 Area of Oral Cavity	26 Tooth System	27 Tooth Number(s) or Letter(s)	28 Tooth Surface	29 Procedure Code	30 Description	31 Fee
1	01/17/2009		JP	12	ODL	D2393	Resin composite-3s, posterior	280.00
2	01/17/2009		JP	13	MODL	D2394	Resin composite-4+s, posterior	350.00
3	01/17/2009		JP	15	ODLB	D2394	Resin composite-4+s, posterior	350.00
4								

24 Procedure Date (MM/DD/YYYY)		25 Area of Oral Cavity	26 Tooth System	27 Tooth Number(s) or Letter(s)	28 Tooth Surface	29 Procedure Code	30 Description	31 Fee
1	03/07/2009		JP	2	MOLB	D2394	Resin composite-4+s, posterior	350.00
2	03/07/2009		JP	3	MOLB	D2394	Resin composite-4+s, posterior	350.00
3	03/07/2009		JP	4	MODL	D2394	Resin composite-4+s, posterior	350.00
4	03/07/2009		JP	5	ODL	D2393	Resin composite-3s, posterior	280.00
5	03/07/2009		JP	31	MOLB	D2394	Resin composite-4+s, posterior	350.00

Experience. Wellness. Everywhere.

84

Billing trend: Case #2b



20. Place of treatment: Office Hosp. ECF Other
 21. First visit date: [redacted] current series: X
 22. City, State, Zip: CHICAGO, IL 60656
 23. Is treatment result of occupational stress or injury? X
 24. Is treatment result of auto accident? X
 25. Other accident? X
 26. If prosthesis, is this initial placement? X (If no, reason for replacement)
 27. Is treatment for orthodontics? X (If service already commenced, enter date appliance placed)

Identify missing teeth with "X"	Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.	Date service performed	Procedure number	Fee
22	MDF Resin-three surfaces, anterior	02 11 2005	D2332	260.00
23	MDF Resin-three surfaces, anterior	02 11 2005	D2332	260.00
24	MDF Resin-three surfaces, anterior	02 11 2005	D2332	260.00
25	MDF Resin-three surfaces, anterior	02 11 2005	D2332	260.00
26	MDF Resin-three surfaces, anterior	02 11 2005	D2332	260.00

Audit Report
Treatment rendered involved a billing practice of periodontal scaling procedures on very young patients, ages 3 to 18.

Billing trend: Case #2c




SSN →

\$\$ → Dr. D. - owner
 Dr. K. - associate

Billing trend: Case #2c



Dr. K. - associate

SSN TIN



Dr. D. - owner

Dr. K. - associate

\$\$

Experience. Wellness. Everywhere.

87

Billing trend: Case #2



Identify theft

*Billing for services
not provided*

Upcoding



U. S. Department of Justice

United States Attorney
Northern District of Illinois

Matthew F. Madden
Assistant United States Attorney

Federal Building
219 South Dearborn Street, Fifth Floor
Chicago, Illinois 60604
Phone: (312) 886-2050
Fax: (312) 353-4324

January 5, 2010

BlueCross BlueShield of Illinois
Attn: James M. Krupkowski, Senior Manager
300 E. Randolph Street
Chicago, Illinois 60601-5099

Re: Federal Grand Jury Subpoena - 09 GJ 1356

Dear Mr. Krupkowski:

The accompanying subpoena has been issued pursuant to an official criminal investigation being conducted by a federal grand jury, and seeks the production of certain records in the custody of BlueCross BlueShield of Illinois. Because this subpoena relates to an ongoing criminal investigation, you are asked not to disclose the existence or nature of the subpoena. Such disclosure could obstruct and impede the ongoing investigation and interfere with the enforcement of the law.

Billing trend: Case #3



Composite Ranking



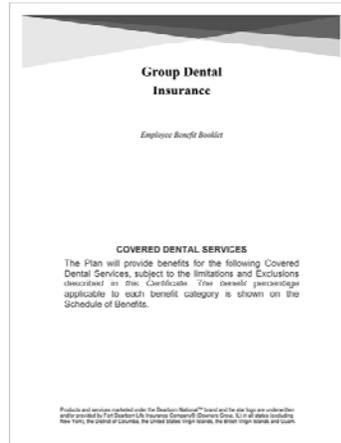
RESTORATIVE	ORAL SURGERY	DOLLARS	MISCELLANEOUS
FBZSC7 Average # Resins / Patient	FBT003 Average # Low Surgical per Simple	FBG003 Total Dollars Charged	FBT086 % Procedures with Palliative Care
FBT017 % Restorations having Pulp Caps	FBT004 Average # High Surgical per Lesser Surgical	FBG002 Average Dollars Charged / Patient	FBG060 Average # Procedures / Patient
FBT008 % Restorations having Pulp Tests			FBG006 Average # Procedures / Visit
FBT001 Average # Pulp			FBG020 Total # of

Billing trend: Case #3



2008	percentage of total
x-rays	41.0%
crown/bridge	17.0%
palliative care	6.0%
root canals	6.0%
21 post removals	
24 root canal retreatments	
121 palliative care	

Billing trend: Case #3



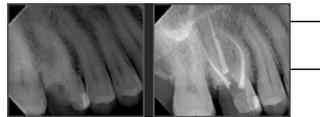
Experience. Wellness. Everywhere.

91

Billing trend: Case #3



Endodontic Therapy



Dental Claim Form
American Dental Association, 2006
01051900229

INSURANCE INFORMATION
Type of Transaction (Check all applicable boxes)
 Renewal of Annual Renewal Renewal by Reinstatement/Reactivation
 Employee Fee For

INSURANCE POLICY INFORMATION
1. Name, Address, City, State, Zip Code
Blue Cross and Blue Shield Of Texas
2. Denial TX 75021
3. Date of Birth (MM/DD/CCYY) 01/11/1973
4. Gender M
5. Plan/Group Number
6. Employee Name
7. Policy/Plan

PATIENT INFORMATION
8. Date of Birth (MM/DD/CCYY) 01/11/1973
9. Gender M
10. Subscriber Identifier (ID# or ID#)
11. Date of Birth (MM/DD/CCYY) 01/11/1973
12. Primary Care Physician (Check appropriate box)
13. Referring Physician (Check appropriate box)
14. Other Caregiver Name, Address, City, State, Zip Code
15. Patient Information at Placement by Service

16. Procedure Code (ICD-9-CM)	17. Tooth Number	18. Tooth Surface	19. Procedure Code	20. Description	21. Fee
Root canals per patient					
					2007
					2008
					2009
Retreatment patients					
					7 (1-4)
					14 (1-4)
					15 (1-2)

Signature
22. Signature and Title
23. Signature and Title
24. Signature and Title
25. Signature and Title
26. Signature and Title
27. Signature and Title
28. Signature and Title
29. Signature and Title
30. Signature and Title
31. Signature and Title
32. Signature and Title
33. Signature and Title
34. Signature and Title
35. Signature and Title
36. Signature and Title
37. Signature and Title
38. Signature and Title
39. Signature and Title
40. Signature and Title
41. Signature and Title
42. Signature and Title
43. Signature and Title
44. Signature and Title
45. Signature and Title
46. Signature and Title
47. Signature and Title
48. Signature and Title
49. Signature and Title
50. Signature and Title
51. Signature and Title
52. Signature and Title
53. Signature and Title
54. Signature and Title
55. Signature and Title
56. Signature and Title
57. Signature and Title
58. Signature and Title
59. Signature and Title
60. Signature and Title
61. Signature and Title
62. Signature and Title
63. Signature and Title
64. Signature and Title
65. Signature and Title
66. Signature and Title
67. Signature and Title
68. Signature and Title
69. Signature and Title
70. Signature and Title
71. Signature and Title
72. Signature and Title
73. Signature and Title
74. Signature and Title
75. Signature and Title
76. Signature and Title
77. Signature and Title
78. Signature and Title
79. Signature and Title
80. Signature and Title
81. Signature and Title
82. Signature and Title
83. Signature and Title
84. Signature and Title
85. Signature and Title
86. Signature and Title
87. Signature and Title
88. Signature and Title
89. Signature and Title
90. Signature and Title
91. Signature and Title
92. Signature and Title
93. Signature and Title
94. Signature and Title
95. Signature and Title
96. Signature and Title
97. Signature and Title
98. Signature and Title
99. Signature and Title
100. Signature and Title

Experience. Wellness. Everywhere.

92

Billing trend: Case #3



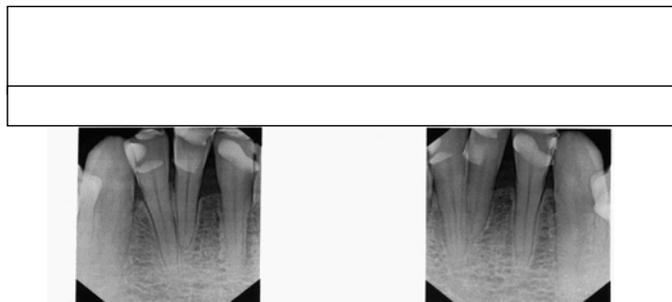
Anterior Crowns

Patient A	Patient B	Patient C	Patient D

Billing trend: Case #3



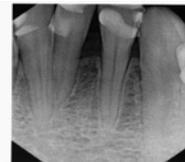
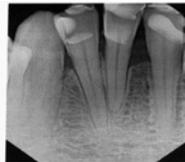
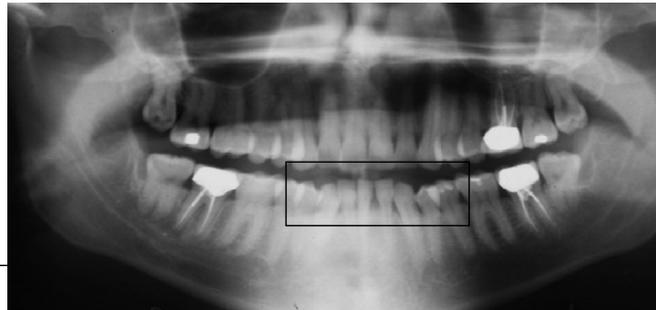
Anterior Crowns



Billing trend: Case #3



Anterior
Crowns



Experience. Wellness. Everywhere.

95

Billing trend: Case #3



Dental Claim Form <small>Professional Dental Association, 2006</small>		01051900229
Insured Identification * Type of Transaction (Check all that apply) <input checked="" type="checkbox"/> Replacement of Natural Denture - DR <input type="checkbox"/> Repair for Prosthodontist/Prostheticologist <input type="checkbox"/> Complete New DR		
Provider Name and Identification _____ _____ _____		Specialty _____ _____ _____
Patient A		
#2 extracted in 2005 #4 crowned in 2005		
Signature on file _____ _____ _____		Signature on file _____ _____ _____

Experience. Wellness. Everywhere.

96

Investigative Trivia #2



Dr. George Grant, 1899

Investigative Trivia #2



Improved golf tee

