Dental Fraud:
The Claim Review Perspective

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Utilization Management
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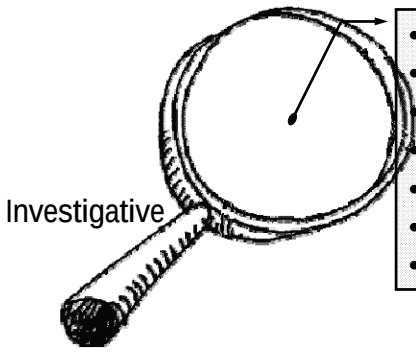
Dental Fraud:
The Claims Review Perspective



- Department of Justice
- FBI
- IRS
- Attorney General
- State Dental Boards
- State Regulatory Depts
- DA

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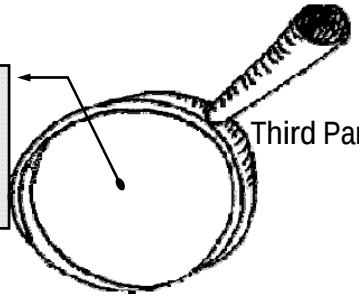
Dental Fraud:
The Claim Review Perspective

- Eligibility
  - Non-Covered
  - ID Falsification
- Group status



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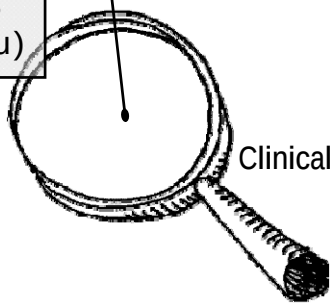
Dental Fraud:
The Claim Review Perspective

- Services Not Rendered
  - Crown Build-ups
  - Prophylaxis vs. 4 QSRP
  - PRR vs. Sealants
  - Gingival restorations
- Drug administrations
- Crown material (%Au)



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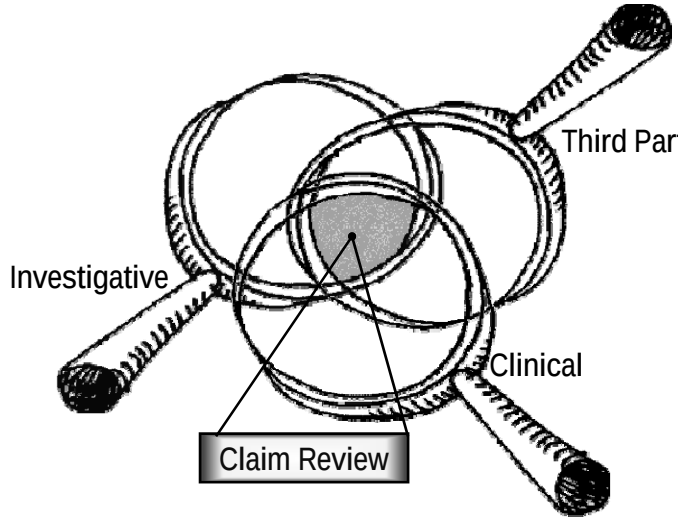
Dental Fraud:
The Claim Review Perspective



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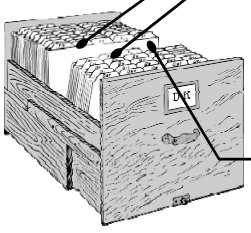
Dental Fraud:
The Claim Review Perspective

- Claim Review
  - Tools



Clinical Staff

Diagnostics
- X-rays / Images
- Photographs
- Provider treatment records

Historical Information
- Diagnostics
- Claim Experience

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Three key issues that determine it is fraud

- DUI:
  - Deception
  - Unlawful gain
  - Intent

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What is Fraud?

- “Fraud" includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit.”
- Obtain something of value by intentional acts of deception, misrepresentation or concealment.
- Fraud is sometimes called the "hidden" crime because we are all victims without even knowing it.
- Dental fraud is any crime where an individual receives insurance money for filing a false claim, inflating a claim or billing for services not rendered.

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What is not Fraud?

- Honest mistakes by the provider
- Situations where the person filing a complaint (states that)
  - "I just knows something is wrong"
  - Feels the bill is just to high
  - Has not received the check
  - "I only saw the Doctor for 10 minutes. How could I be charged this much?"

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What is not Fraud?

nent plans - List teeth in order

Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
			D9220		Deep sedat/gen anesth-1st 30m	172.00
1			D7240		Extraction-impacted/compl bony	237.00
16			D7240		Extraction-impacted/compl bony	237.00
16			D7240		Extraction-impacted/compl bony	237.00
17			D7240		Extraction-impacted/compl bony	237.00
32			D7240		Extraction-impacted/compl bony	237.00

10

What is not Fraud?

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	03152010			18		D6752	CRN-PORCELAIN W/NOBLE	62000
2	03152010			18		D2950	CROWN BUILD-UP INCL PINS	13800
3	03152010			21		D6752	CRN-PORCELAIN W/NOBLE	62000
4	03152010			21		D2954	POST/CORE PREFAB ADD'L CRO	18000

2ND Claim Sent.
please process For Payment.
X-RAYS Were Sent Both times.

MISSING TEETH INFORMATION — 34. (Place an 'X' on each missing tooth): X on 20, 19

32. Other Fee(s) — 33. Total Fee 1558.00

35. Remarks: Bridge Done in 2 Parts. #19 and #20 are missing.

	24. Procedure Date	27. Tooth	29. Procedure Code	30. Description	31. Fee
1	04022010	20 *	D7210	SURGICAL REMOVAL-ERUPTED	13000
2	04022010	22	D6752	CRN-PORCELAIN W/NOBLE	62000
3	04022010	22	D2950	CROWN BUILD-UP INCL PINS	13800
4	04022010	20	D6242	PONTIC PORC W/NOBLE	62000
5	04022010	19	D6242	PONTIC PORC W/NOBLE	62000

MISSING TEETH INFORMATION — 34. (Place an 'X' on each missing tooth)

32. Other Fee(s) — 33. Total Fee 2128.00

35. Remarks: Bridge Done in 2 Parts #19 AND #20 are missing. #20 Ext. on 4/2/10

What is not Fraud?

FEB 15 2010 — RMH, Limited exam, 2PAs, Pt. Presented with Pain in lower left. Existing PFM bridge from #21-#18. Bridge is loose and there is a recurrent decay under the #21. Recommend replacing the bridge and possible RCT #21 and #18. Pt. referred to Endo for evaluating #18 and #21 for possible RCT. [illegible] N.V. replacing bridge

3/9/10 — RMH, pt presents for evaluation for a 4unit bridge. #18 to 21. existing bridge is loose on #18, fractured on #21 + pontic w/ recurrent decay #18. Recommend new bridge. Discussed w/ pt.

MAR 15 2010 — 18-21 — RMH, Pt Presents for reimpress Bridge. 2 carps 2% lido 1/100k epi -Asp. removed existing bridge. Removed temps #18 + 21. placed post in #21 w/ [illegible]. [illegible] bond + BU w/ paste composite. prepped #18+21 as abutments. #20 non restorable due to extent of decay. Recommend ext + extent bridge to #22. NV: ext #20 + prep #22. Turbo temp provisional fabricated + cemented w/ temp-bond.

APR 02 2010 — 18-22 — RMH. 3 carps 2% lido 1/100k epi -Asp. removed Bridge 18-22. prepped #22 as abutment for bridge - separated attached tissue #20. Removed 3mm buccal bone w/ copious irrigation. Delivered #20 w/ root tip picks. curetted socket. Irrigated peridex. packed socket w/ gel foam. Hemostasis achieved w/ sterile gauze. 3x4.0 gut sutures placed. Impressed for pfm bridge #18-22. Turbo temp provisional fabricated + cemented w/ temp bond. ✓ margin, contacts + occlusion

4-2-10 [illegible] — Rx Amox. 500mg #30 caps Vicodin 5/500 #20 tabs 1-2 q4-6hrs

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Claim System Experience
"Red Flags"

- Claim experience (history)
  - Consistent billing at 'highest' level
  - Unsigned claims
  - Letterhead not used in narratives
  - Requested receipts or records are unidentified

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Claim System Experience
"Red Flags"

- Individual Claim
  - Provider not in same geographical area as member
  - Misspelled or misused terminology
  - Provider and member have same address
  - Erasures, strikeovers or other alterations
  - Unsigned claims
  - Letterhead not used in narratives
  - Requested receipts or records are unidentified

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Areas of fraud

- Claim Review Related
  - Billing for services not performed
  - Upcoding
  - Altering And/or Falsification of:
    - Dates of services
    - Diagnostics
  - Unbundling / (Intentional) Improper use of codes
- Non-Claim Review Related
  - Misrepresenting patient identities
  - Not disclosing existence of additional or primary coverage
  - Waiver of co-payments and/or deductibles

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Billing for services not performed

- Appears self explanatory
  - What about billing for prep date vs. seat date for a crown?
    - When is the service actually performed?

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Billing for services not performed

- Claim experience can provide ‘clues’
  - Claim history and patterns
  - Examples
    - Repetitive submissions

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Billing for services not performed
Multiple Dates: Same Service

Laguna Niguel CA 92607

05/16/2006 | G00012

RECORD OF SERVICES PROVIDED

	24 Procedure Date (MM/DD/CCYY)	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	03/15/2010		JP			D0140	Limited oral evaluation	50 00
2	03/15/2010		JP			D0220	Intraoral-periapical-1st film	20 00
3	03/15/2010		JP			D0230	Intraoral-periapical-each add1	15 00
4	03/15/2010		JP			D0240	Intraoral-occlusal film	33 00
5	03/15/2010		JP			D0240	Intraoral-occlusal film	33 00
6	03/15/2010		JP			D1120	Prophylaxis-child	56 00
7	03/15/2010		JP			D1203	Fluoride w/o prophylaxis-child	44 00
8								
9								
10								

32 Other Fee(s)

33 Total Fee 251 00

MISSING TEETH INFORMATION

Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Primary: A B C D E F G H I J / T S R Q P O N M L K

34 (Place an 'X' on each missing tooth)

35 Remarks

AUTHORIZATIONS

38. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

x SIGNATURE ON FILE 03/15/2010

Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly, to the below-named dentist or dental entity.

x SIGNATURE ON FILE 03/15/2010

Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

39 Number of Enclosures (00 to 99): Attached 00 Transmitted 00 Code 00

[X] Provider's Office [ ] Hospital [ ] EDF [ ] Other

40 Is Treatment for Orthodontics? [X] No (See #41-42) [ ] Yes (Complete #41-42)

41 Date Appliance Placed (MM/DD/CCYY)

42 Months of Treatment Remaining

43 Replacement of Prosthesis? [X] No [ ] Yes (Complete 44)

44 Date Prior Placement (MM/DD/CCYY)

45 Treatment Resulting from (Check applicable box): [ ] Occupational illness/ injury [ ] Auto accident [ ] Other accident

46 Date of Accident (MM/DD/CCYY)

47 Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48 Name, Address, City, State, Zip Code

DDS

Suite 165

San Juan Capistrano CA 92675

49 Provider ID | 50 License Number 4 9 | 51 SSN or TIN 2 2

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated to date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for these procedures.

Signature On File 03/15/2010

Signed (Treating Dentist) Date

54 Provider ID | 55 License Number 4 8

56 Address, City, State, Zip Code

Suite 165

San Juan Capistrano CA 92675

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Billing for services not performed

Multiple Dates: Same Service

9 Plan/Group Number	10 Relationship to Primary Subscriber (Check applicable box) Self ☐ Spouse ☐ Dependent ☐ Other					G	D	
11 Other Carrier Name, Address, City, State, Zip Code						Laguna Niguel	CA	92607
						21 Date of Birth (MM/DD/CCYY) 05/16/2006	22 Gender ☒ M ☐ F	23 Patient ID/Account # (Assigned by Dentist) GO0012

RECORD OF SERVICES PROVIDED

	24 Procedure Date (MM/DD/CCYY)	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	03/24/2010		JP			D0140	Limited oral evaluation	50.00
2	03/24/2010		JP			D1120	Prophylaxis-child	56.00
3	03/24/2010		JP			D1203	Fluoride w/o prophylaxis-child	44.00
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION — Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 — Primary: A B C D E F G H I J / T S R Q P O N M L K

34 (Place an 'X' on each missing tooth) — 32 Other Fee(s) — 33 Total Fee 150.00

35 Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or [illegible] of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

x SIGNATURE ON FILE 03/24/2010
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below-named dentist or dental entity.

x SIGNATURE ON FILE 03/24/2010
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
DDS
Suite 165
San Juan Capistrano CA 92675

49. Provider ID | 50. License Number 4 8 | 51. SSN or TIN 2 2

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☒ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible]
39. Number of Enclosures (00 to 99) [00] [00] [00]
40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☒ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

52. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
x Signature On File 03/24/2010
Signed (Treating Dentist) Date
54. Provider ID | 55. License Number 4 8
56. Address, City, State, Zip Code Suite 165 San Juan Capistrano CA 92675

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Billing for services not performed

Multiple Dates: Same Service

9 Plan/Group Number	10 Relationship to Primary Subscriber (Check applicable box) Self ☐ Spouse ☐ Dependent ☐ Other					G	D	
11 Other Carrier Name, Address, City, State, Zip Code						Laguna Niguel	CA	92607
						21 Date of Birth (MM/DD/CCYY) 05/16/2006	22 Gender ☒ M ☐ F	23 Patient ID/Account # (Assigned by Dentist) GO0012

RECORD OF SERVICES PROVIDED

	24 Procedure Date (MM/DD/CCYY)	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	04/09/2010		JP			D0140	Limited oral evaluation	50.00
2	04/09/2010		JP			D1120	Prophylaxis-child	56.00
3	04/09/2010		JP			D1203	Fluoride w/o prophylaxis-child	44.00
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION — Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 — Primary: A B C D E F G H I J / T S R Q P O N M L K

34 (Place an 'X' on each missing tooth) — 32 Other Fee(s) — 33 Total Fee 150.00

35 Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or [illegible] of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

x SIGNATURE ON FILE 04/09/2010
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below-named dentist or dental entity.

x SIGNATURE ON FILE 04/09/2010
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
DDS
Suite 165
San Juan Capistrano CA 92675

49. Provider ID | 50. License Number 4 8 | 51. SSN or TIN 2 2

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) [00] [00] [00]
40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☒ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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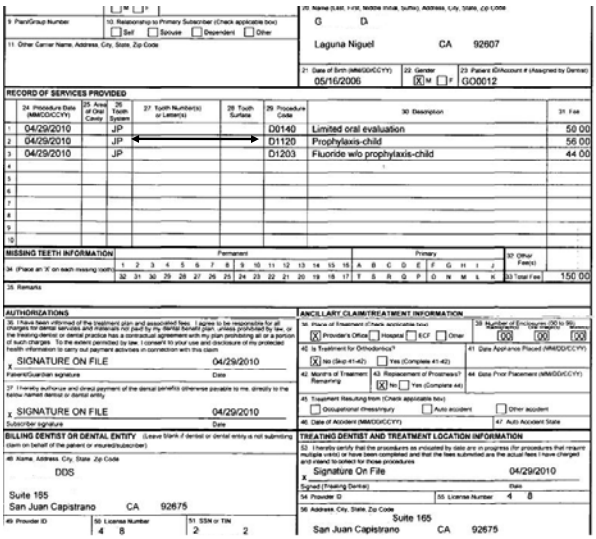
x Signature On File 04/09/2010
Signed (Treating Dentist) Date
54. Provider ID | 55. License Number 4 8
56. Address, City, State, Zip Code Suite 165 San Juan Capistrano CA 92675

20

Billing for services not performed

Multiple Dates: Same Service



	Procedure Date	Area of Oral Cavity	Tooth System	Tooth Number(s) or Letter(s)	Tooth Surface	Procedure Code	Description	Fee
1	04/29/2010		JP			D0140	Limited oral evaluation	50 00
2	04/29/2010		JP			D1120	Prophylaxis-child	56 00
3	04/29/2010		JP			D1203	Fluoride w/o prophylaxis-child	44 00

Laguna Niguel CA 92607

05/16/2006 | M | GO0012

SIGNATURE ON FILE 04/29/2010

SIGNATURE ON FILE 04/29/2010

DDS

Suite 185
San Juan Capistrano CA 92675

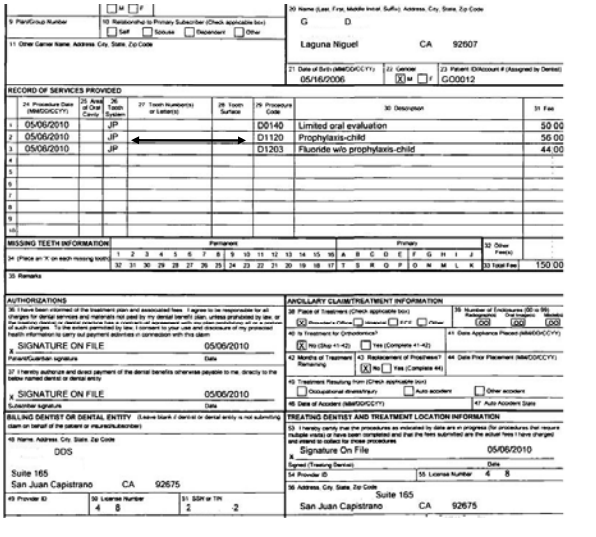
Signature On File 04/29/2010

Suite 165
San Juan Capistrano CA 92675

21

Billing for services not performed

Multiple Dates: Same Service



	Procedure Date	Area of Oral Cavity	Tooth System	Tooth Number(s) or Letter(s)	Tooth Surface	Procedure Code	Description	Fee
1	05/06/2010		JP			D0140	Limited oral evaluation	50 00
2	05/06/2010		JP			D1120	Prophylaxis-child	56 00
3	05/06/2010		JP			D1203	Fluoride w/o prophylaxis-child	44 00

Laguna Niguel CA 92607

05/16/2006 | M | GO0012

SIGNATURE ON FILE 05/06/2010

SIGNATURE ON FILE 05/06/2010

DDS

Suite 165
San Juan Capistrano CA 92675

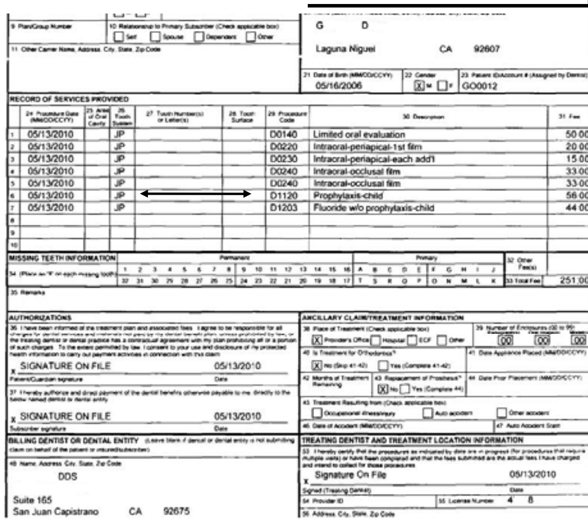
Signature On File 05/06/2010

Suite 165
San Juan Capistrano CA 92675

22

Billing for services not performed

Multiple Dates: Same Service



9 Plan/Group Number

10 Relationship to Primary Subscriber (Check applicable box) Self Spouse Dependent Other

11 Other Carrier Name, Address, City, State, Zip Code

G D

Laguna Niguel CA 92607

21 Date of Birth (MM/DD/CCYY) 05/16/2006

22 Gender [X] M [ ] F

23 Patient ID/Account # (Assigned by Dentist) GO0012

RECORD OF SERVICES PROVIDED

	24 Procedure Date (MM/DD/CCYY)	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	05/13/2010		JP			D0140	Limited oral evaluation	50.00
2	05/13/2010		JP			D0220	Intraoral-periapical-1st film	20.00
3	05/13/2010		JP			D0230	Intraoral-periapical-each add'l	15.00
4	05/13/2010		JP			D0240	Intraoral-occlusal film	33.00
5	05/13/2010		JP			D0240	Intraoral-occlusal film	33.00
6	05/13/2010		JP	←	→	D1120	Prophylaxis-child	56.00
7	05/13/2010		JP			D1203	Fluoride w/o prophylaxis-child	44.00
8								
9								
10								

MISSING TEETH INFORMATION

34	Permanent																Primary										32 Other Fee(s)	
	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		
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33 Total Fee	251.00

35 Remarks

AUTHORIZATIONS

x SIGNATURE ON FILE 05/13/2010

Patient/Guardian signature Date

x SIGNATURE ON FILE 05/13/2010

Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38 Place of Treatment (Check applicable box) [X] Provider's Office [ ] Hospital [ ] ECF [ ] Other

39 Number of Enclosures (00 to 99) 00 00 00

40 Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41 Date Appliance Placed (MM/DD/CCYY)

42 Months of Treatment Remaining

43 Replacement of Prosthesis? [X] No [ ] Yes (Complete 44)

44 Date Prior Placement (MM/DD/CCYY)

45 Treatment Resulting from (Check applicable box) [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46 Date of Accident (MM/DD/CCYY)

47 Auto Accident State

BILLING DENTIST OR DENTAL ENTITY

48 Name, Address, City, State, Zip Code

DDS

Suite 165

San Juan Capistrano CA 92675

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

x Signature On File 05/13/2010

Signed (Treating Dentist) Date

54 Provider ID

55 License Number 4 8

56 Address, City, State, Zip Code

23

Billing for services not performed

Multiple Dates: Same Service

- Investigation
  - Multiple patient lines
  - Pattern uncovered
    - Claim submissions upsurge 2009
      - Plan participation change late 2008
    - 2 -3 week intervals
    - Exam, occlusal films, bite wings, prophy, fluoride application
  - On site facility review

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Billing for services not performed

- Claim experience can provide ‘clues’
  - Claim history and patterns
  - Examples
    - Crowns and Crown build-ups on all submissions

25

Billing for services not performed

Crowns and Crown build-ups

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	05/18/2010		JP	20		D2950	Crown buildup, includ any pins	124.00
2	05/18/2010		JP	21		D2950	Crown buildup, includ any pins	124.00
3	05/18/2010		JP	22		D2950	Crown buildup, includ any pins	124.00
4	06/03/2010		JP	20		D2740	Crown-porcelain/ceramic substr	693.00
5	06/03/2010		JP	21		D2740	Crown-porcelain/ceramic substr	693.00
6	06/03/2010		JP	22		D2740	Crown-porcelain/ceramic substr	693.00
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
X	X	X	X	5	6	7	8	9	10	11	X	13	X	15	X	A	B	C	D	E	F	G	H	I	J		
X	X	X	X	26	27	X	X	X	X	22	21	20	X	X	X	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	2451.00

35. Remarks: pre-op x-rays attached #20 & #21 had huge existing failed restor. with 2ndary decay. #22 had existing failed restor. with 2ndary decay, fract. distal cusp & entire lingual wall. After removing decay & fractured tooth structure buildups were nec. to support

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X SIGNATURE ON FILE — 06/03/2010
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X SIGNATURE ON FILE — 06/03/2010
Subscriber signature — Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
J
Suite 4
Chandler AZ 85286

49. NPI: 3226
50. License Number: 6
51. SSN or TIN: 2 72
52. Phone Number: (480) 306 –
52A. Additional Provider ID:

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: [X] Provider's Office [ ] Hospital [ ] ECF [ ] Other
39. Number of Enclosures (00 to 99): Radiographs(X-rays) 02; Oral Images(s) 00; Model(s) 00
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? [X] No [ ] Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from: [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X J — 06/03/2010
Signed (Treating Dentist) — Date

54. NPI: 3226
55. License Number: 6
56. Address, City, State, Zip Code: Suite 4, Chandler AZ 85286
56A. Provider Specialty Code
57. Phone Number: (480) 306–
58. Additional Provider ID

26

Billing for services not performed

Crowns and Crown build-ups

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	08/01/2009		JP	30		D2950	Crown buildup, includ any pins	124.00
2	08/01/2009		JP	31		D2950	Crown buildup, includ any pins	124.00
3	08/12/2009		JP	30		D2740	Crown-porcelain/ceramic substr	693.00
4	08/12/2009		JP	31		D2740	Crown-porcelain/ceramic substr	693.00

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	05/08/2010		JP	14		D2950	Crown buildup, includ any pins	124.00
2	05/08/2010		JP	19		D2950	Crown buildup, includ any pins	124.00
3	05/25/2010		JP	14		D2740	Crown-porcelain/ceramic substr	693.00
4	05/25/2010		JP	19		D2740	Crown-porcelain/ceramic substr	693.00

MISSING TEETH INFORMATIO

34. (Place an 'X' on each missing too

35. Remarks pre op xray atte restorations wit

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	05/18/2010		JP	27		D2950	Crown buildup, includ any pins	124.00
2	05/18/2010		JP	28		D2950	Crown buildup, includ any pins	124.00
3	06/01/2010		JP	27		D2740	Crown-porcelain/ceramic substr	693.00
4	06/01/2010		JP	28		D2740	Crown-porcelain/ceramic substr	693.00

MISSING TEETH INFORMATION

Permanent															Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	A	B	C	D	E	F	G	H	I	J		
X	X	X	X									X		X											33. Total Fee	1634.00
X	X	X	X	28	27	X	X	X	X	22	21	20	X	X	T	S	R	Q	P	O	N	M	L	K		

34. (Place an 'X' on each missing tooth)

35. Remarks pre-op xray attached. #27 Had large existing failed restoration with 2ndary decay & entire lingual wall fractured. #28 had huge existing failed retoration with 2ndary decay. Build ups were necessary to support crowns

Billing for services not performed

Crowns and Crown build-ups

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	05/20/2010		JP	14		D2950	Crown buildup, includ any pins	124.00
2	06/01/2010		JP	14		D2740	Crown-porcelain/ceramic substr	693.00

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	05/20/2010		JP	15		D2950	Crown buildup, includ any pins	124.00
2	06/01/2010		JP	15		D2740	Crown-porcelain/ceramic substr	693.00

MISSING TEETH INFI

34. (Place an 'X' on each

35. Remarks pre-op x non-fun

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	08/07/2009		JP	19		D2950	Crown buildup, includ any pins	124.00
2	08/18/2009		JP	19		D2740	Crown-porcelain/ceramic substr	693.00

MISSING TEETH INF

34. (Place an 'X' on each

35. Remarks pre-op decay

MISSING TEETH INFORMATION

Permanent															Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	A	B	C	D	E	F	G	H	I	J		
X				X						X				X											33. Total Fee	817.00
X	31	30	29	X	27	26	25	24	23	22	X	20	19	18	X	T	S	R	Q	P	O	N	M	L	K		

34. (Place an 'X' on each missing tooth)

35. Remarks Pre-op xrays attached. Pt lost 21 year old existing crown due to severe secondary decay.After removing all decay & fractured tooth structure buildup was necessary to support new crown

Billing for services not performed

- Claim experience can provide ‘clues’
  - Submitted diagnostics can be of value

29

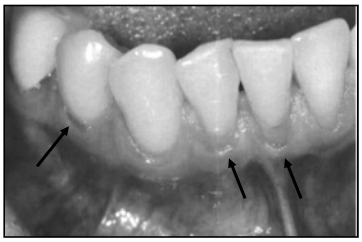
Billing for services not performed

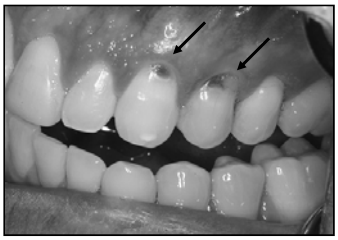
- Claim experience can provide ‘clues’
  - Submitted diagnostics can be of value
  - Submitted diagnostics have limitations

30

Billing for services not performed

- Diagnostic limitations
  - Example: Gingival (gum line) restorations (CDT code: D2330)

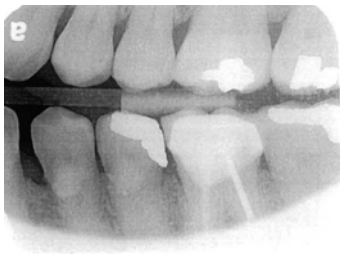


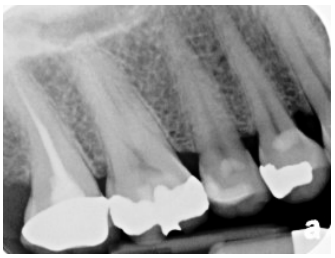


31

Billing for services not performed

- Diagnostic limitations
  - Example: Gingival (gum line) restorations (CDT code: D2330)





32

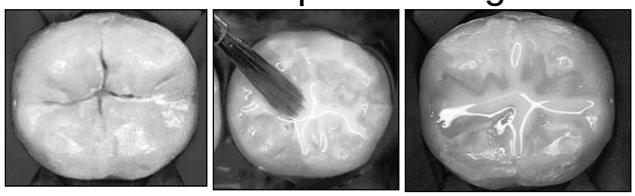
Billing for services not performed

- Diagnostic limitations
  - Example: Dental Sealants (CDT code: D1315) vs Composite Resins (fillings) (CDT code: D2391)

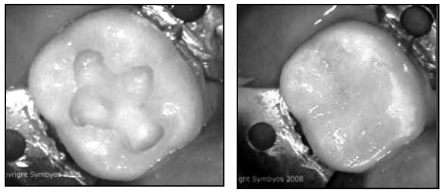
33

Billing for services not performed

- Sealants vs Composite fillings



Dental Sealants (CDT code: D1315)

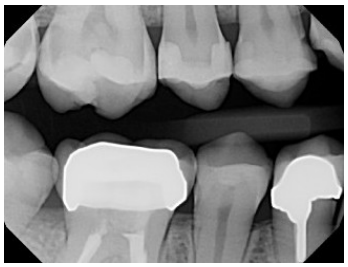


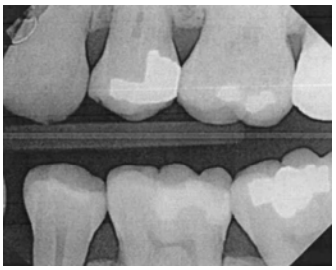
Composite fillings (CDT code: D2391)

34

Billing for services not performed

- Diagnostic limitations
  - Example: Dental Sealants (CDT code: D1315) vs Composite Resins (fillings) (CDT code: D2391)





35

Upcoding

- Coding a procedure as having a more extensive degree of difficulty

36

Upcoding

- Coding a procedure as having a more extensive degree of difficulty

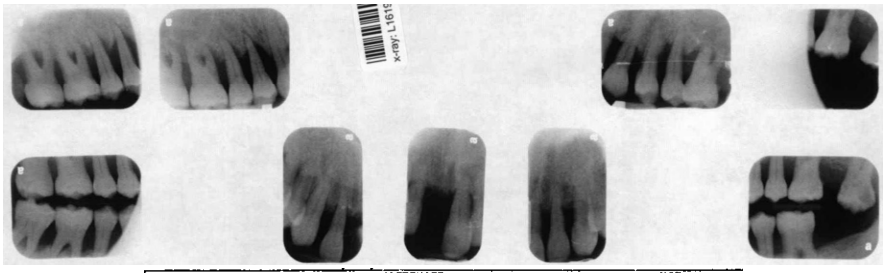
D7111 extraction, coronal remnants – deciduous tooth: Removal of soft tissue-retained coronal remnants

D7140 extraction, erupted tooth or exposed root (elevation and/or forceps removal): Includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.

D7210 surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth: Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.*

37

Upcoding



SERVICE DATES	TOOTH NUM.	SURFACE	SERVICE CODE	ALTERNATE BENEFIT CODE	SUBMITTED CHARGES	NEGOTIATED AMOUNT	NOT PAYABLE BY PLAN	RI
	11		D7210		260.00		260.00	
	10		D7210		260.00		260.00	
	09		D7210		260.00		260.00	
	04		D7210		260.00		260.00	
	03		D7210		260.00		260.00	
	02		D7210		260.00		260.00	
Totals:					1,560.00		1,560.00	

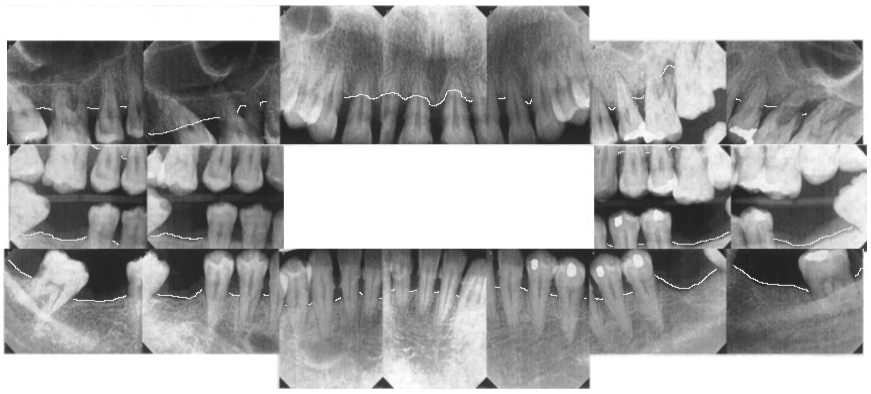
38

Upcoding

1			JP		D9243	Intravenous Analgesia - First 30 Minutes	350.00
2			JP	01	D7210	Surgical Removal Of Erupted Tooth	200.00
3			JP	03	D7210	Surgical Removal Of Erupted Tooth	200.00
4			JP	04	D7210	Surgical Removal Of Erupted Tooth	200.00
5			JP	05	D7210	Surgical Removal Of Erupted Tooth	200.00
6			JP	06	D7210	Surgical Removal Of Erupted Tooth	200.00
7			JP	07	D7210	Surgical Removal Of Erupted Tooth	200.00
8			JP	08	D7210	Surgical Removal Of Erupted Tooth	200.00
9			JP	09	D7210	Surgical Removal Of Erupted Tooth	200.00
10	--- Continued on next form ---						
1			JP	10	D7210	Surgical Removal Of Erupted Tooth	200.00
2			JP	11	D7210	Surgical Removal Of Erupted Tooth	200.00
3			JP	12	D7210	Surgical Removal Of Erupted Tooth	200.00
4			JP	13	D7210	Surgical Removal Of Erupted Tooth	200.00
5			JP	15	D7210	Surgical Removal Of Erupted Tooth	200.00
6			JP	16	D7210	Surgical Removal Of Erupted Tooth	200.00
7			JP	17	D7210	Surgical Removal Of Erupted Tooth	200.00
8			JP	20	D7210	Surgical Removal Of Erupted Tooth	200.00
9			JP	21	D7210	Surgical Removal Of Erupted Tooth	200.00
10	--- Continued on next form ---						
1			JP	22	D7953	Bone Replacement Graft For Ridge Preservation--Per S	400.00
2			JP	22	D7210	Surgical Removal Of Erupted Tooth	200.00
3			JP	23	D7210	Surgical Removal Of Erupted Tooth	200.00
4			JP	24	D7210	Surgical Removal Of Erupted Tooth	200.00
5			JP	25	D7210	Surgical Removal Of Erupted Tooth	200.00
6			JP	26	D7210	Surgical Removal Of Erupted Tooth	200.00
7			JP	27	D7953	Bone Replacement Graft For Ridge Preservation--Per S	400.00
8			JP	27	D7210	Surgical Removal Of Erupted Tooth	200.00
9			JP	28	D7210	Surgical Removal Of Erupted Tooth	200.00
10	--- Continued on next form ---						
1			JP	29	D7210	Surgical Removal Of Erupted Tooth	200.00
2			JP	32	D7210	Surgical Removal Of Erupted Tooth	200.00

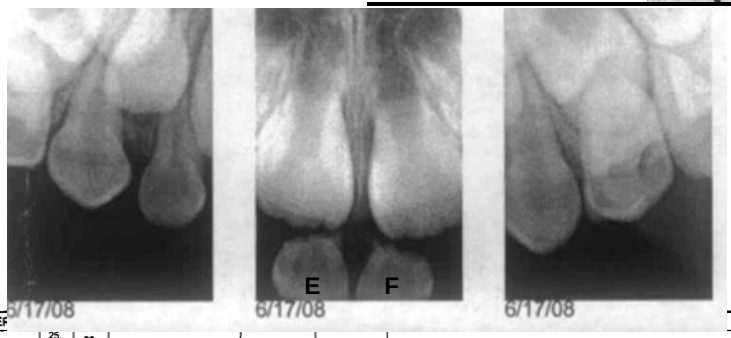
39

Upcoding



40

Upcoding

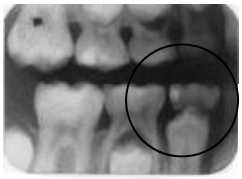


RECORD OF SE

24. Procedure Date (MM/DD/CCYY)	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
6/17/2008					D0210	Full Mouth X-Rays	150.00
6/17/2008					D0120	Periodic Oral Exam	125.00
6/17/2008					D1120	Prophylaxis	135.00
6/17/2008					D1203	Fluoride Treatment	135.00
6/17/2008			E		D7210	Surgical Extraction	250.00
6/17/2008			F		D7210	Surgical Extraction	250.00

41

Upcoding



SERVICE DATES	SERVICE CODE	ALTERNATE BENEFIT CODE	TOOTH NUM.	SURFACE	NUM. SVCS	SUBMITTE CHARGE:	Date: 6/12/2010	SEE EMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
06/12/10	D7210		S			169.00		1				0.00
TOTALS						169.00						0.00

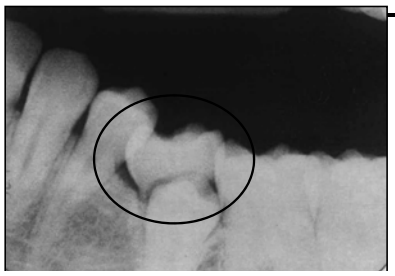
Please see attached x ray ISSUED AMT: NO PAY

Remarks:

1 - The following additional items are required to determine whether this charge is covered under your patient's benefit plan: current pre-operative x-rays, dated and marked right and left, of the teeth being treated. Please forward these materials to the address on this statement. To insure proper identification and tracking of this claim, include this

42

Upcoding

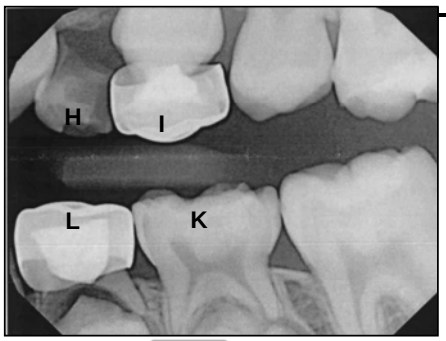


RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	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 07182011			K		D7210	SURGICAL RMVL-ERUPTED TOOT	283 00

43

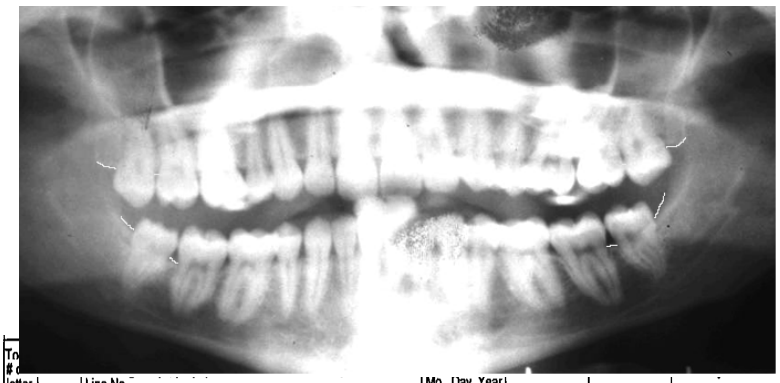
Upcoding



07/18/2011		JP	H		D7210	Extraction-surgical/erupt tooth	265 00
07/18/2011		JP	I		D7210	Extraction-surgical/erupt tooth	265 00
07/18/2011		JP	L		D7210	Extraction-surgical/erupt tooth	265 00

44

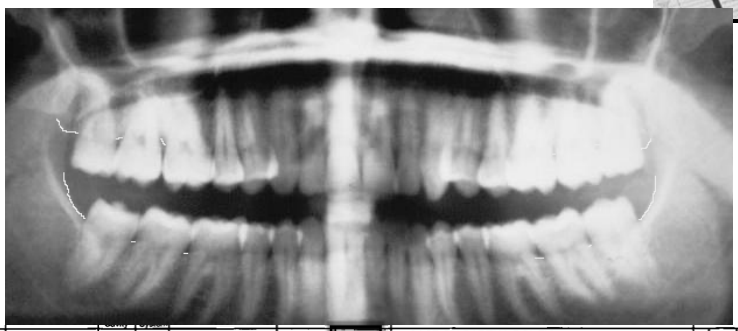
Upcoding



To # of letter	Line No.	Mo. Day Year			
1	Surg Rem Impacted, Complete bony Impact. Unusual C		D7241	345.00	
16	Surg Rem Impacted, Complete bony Impact. Unusual C		D7241	345.00	
17	Surg Rem Impacted, Complete bony Impact. Unusual C		D7241	345.00	
32	Surg Rem Impacted, Complete bony Impact. Unusual C		D7241	345.00	
	pre-meds		D9230	85.00	

45

Upcoding



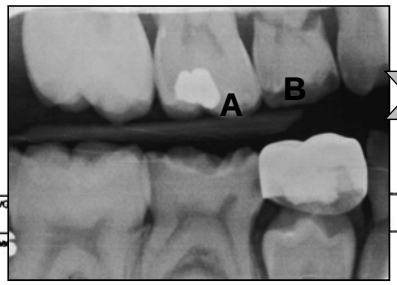
1			32	D7230	IMPACTION-PARTIAL BONEY	346	00
2			17	D7230	IMPACTION-PARTIAL BONEY	346	00
3			16	D7230	IMPACTION-PARTIAL BONEY	346	00
4			01	D7230	IMPACTION-PARTIAL BONEY	346	00
5				[illegible]	ANESTHESIA-GENERAL	316	00
6							
7							
8							
9							
10							

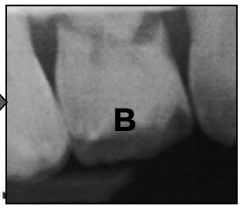
MISSING TEETH INFORMATION	Permanent															Primary										32. Other Fee(s)		
34. (Place an 'X' on each missing tooth)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	33.Total Fee	1700	00
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K			

35. Remarks AUTH#V06092011 SEE ATTACHED X-RAY

46

Abuse





20. Name (Last, First, Middle
K J
187
, CO 81007

21. Date of Birth (MM/DD/CCYY) 01 / 24 / 2001
22. Gender ☐ M ☒ F
23. Patient ID/Account # (Assigned by Dentist) W1 81

ECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	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
01/07/2011		JP			D9230	ANALGESIA	57 00
01/07/2011		JP	B		D2930	PREFAB. STAINLESS STEEL CROWN-PRIMARY	215 00
01/07/2011		JP	A		D2930	PREFAB. STAINLESS STEEL CROWN-PRIMARY	215 00

47

Abuse

☒ Enhanced Magnification and lighting used

ECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	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
08/04/2011		JP	6		D3331	TREAT ROOT CANAL OBSTRUCT	166.00
08/04/2011		JP	6		D3221	RELIEF ACUTE PAIN	48.00
08/04/2011		JP	7		D3331	TREAT ROOT CANAL OBSTRUCT	166.00
08/04/2011		JP	7		D3221	RELIEF ACUTE PAIN	48.00

☒ Munce "Discover Burs" used
☒ LN Burs Used
○ Extra Long Burs Used
○ Small Round Burs Used

○ Deep groove cut to gain access to accessory canals

○ Multiple radiographs taken to help localize canals

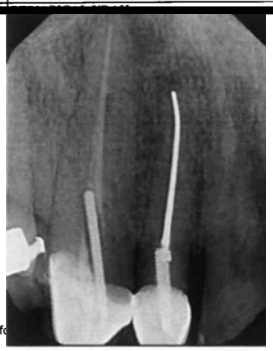
○ Fiber-optic lighting used to help locate calcified canals

Obstruction present
○ 50%
○ 60%
☒ 70%
○ 80%

○ Groove cut at 50% to help locate calcified canal

○ MTA (Mineral Tri-Oxide) aggregate cement used as coronal seal fo

☒ Extra time needed to complete procedure.



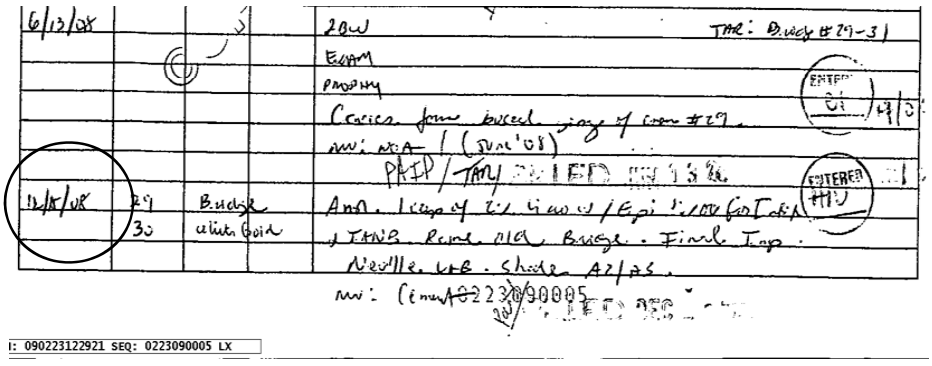
48

Altering dates of services

- Submitting a claim for treatment using a date other than the actual date of service to secure payment is considered a fraudulent act.
  - Correct dates are relevant to patient eligibility requirements and waiting periods.

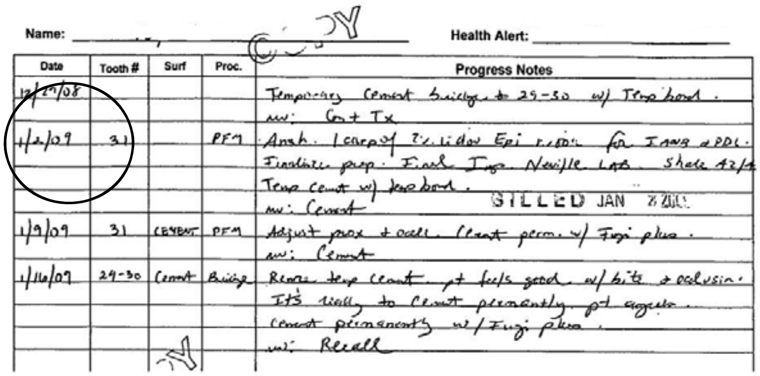
49

Altering dates of services



50

Altering dates of services

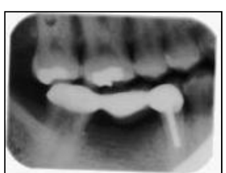


Name: Health Alert:

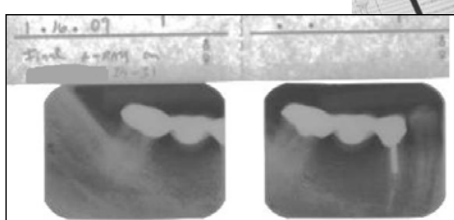
Date	Tooth #	Surf	Proc.	Progress Notes
12/29/08				Temporary Cement Bridge to 29-30 w/ Temp bond.
				nv: Cr + Tx
1/2/09	31		PFM	Anesh. 1 carp of 2% Lido Epi 1:100k for IANB & PDL.
				Finalize prep. Final Imp. Neville Lab. Shade A2/A
				Temp cemt w/ temp bond.
				nv: Cement BILLED JAN 2009
1/9/09	31	CEMENT	PFM	Adjust prox & occl. Cement perm. w/ Fuji plus.
				nv: Cement
1/16/09	29-30	Cement	Bridge	Remove temp cement. pt feels good w/ bite & occlusion.
				It's ready to cement permanently. pt agrees.
				cement permanently w/ Fuji plus.
				nv: Recall

51

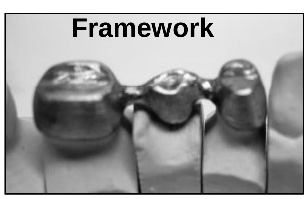
Altering dates of services



Date: 6/13/2008



Date: 1/16/2009



52

Altering dates of services

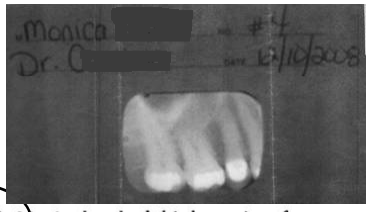
- Submitting a claim for treatment using a date other than the actual date of service to secure payment is considered a fraudulent act.
  - Supporting documentation can be suspect
    - Narratives

53

Altering dates of services

April 24, 2009

UniCare Insurance:

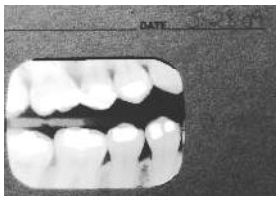


I wanted to help clarify the status for Monica crown on #4. Monica has had this large 4 surface amalgam filling for quite a few years, and now, there is recurrent decay on the mesial and distal aspect. (see attached radiograph). Our hygiene team has charted consistent 4-5mm pocketing in that area (due to food impaction) while the rest of her mouth is (periodontally) quite healthy. The caries is my main concern, and in order to remove the caries, it is necessary to remove the existing amalgam so that we can remove the caries and then, fabricate a D2750 for #4 so that her teeth and periodontium can remain healthy for a long time to come.

I hope this helps, please contact us shall you need any further clarification.

54

Altering dates of services



September 18, 2009

Aetna Insurance:

I wanted to help clarify the ongoing status for the crown for Monica on tooth #4. The crown was originally completed on 12.01.2008 on tooth #4. But after that, due to porcelain fracture, we had to remake the crown again on 05.28.2009. But on 05.28.2009, we accidentally billed out for another crown on tooth #4, which was our error and for that, we apologize.

Please disregard this claim and do not proceed with it any further.

I hope this helps, please contact us shall you need any further clarification.

55

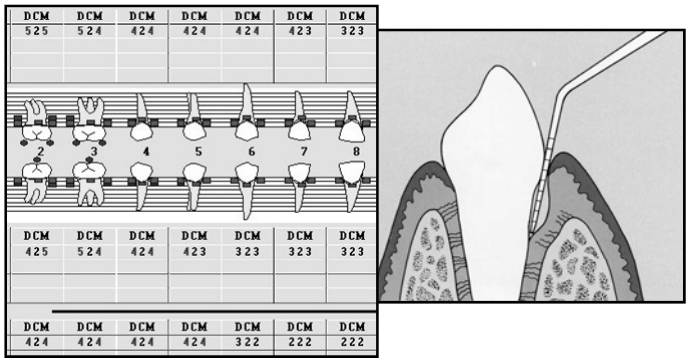
Alteration / Falsification of diagnostics

- Submitting diagnostics in support of treatment using data other than the actual data relevant to that of the actual service to secure payment is considered a fraudulent act.
  - Accurate and correct data is relevant to appropriate adjudication of the submission.

56

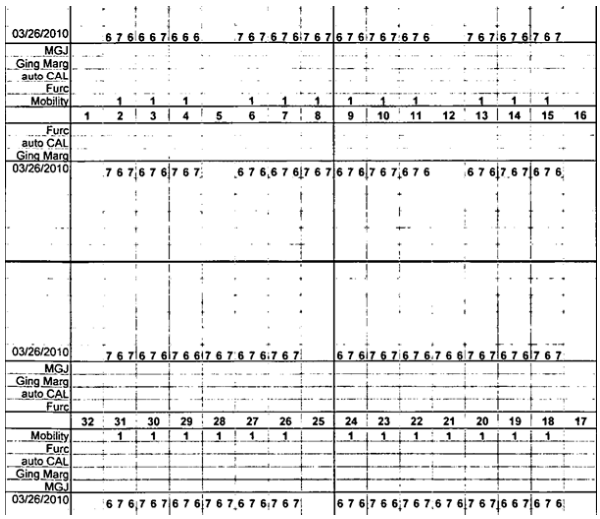
Alteration / Falsification of diagnostics

- Periodontal charting



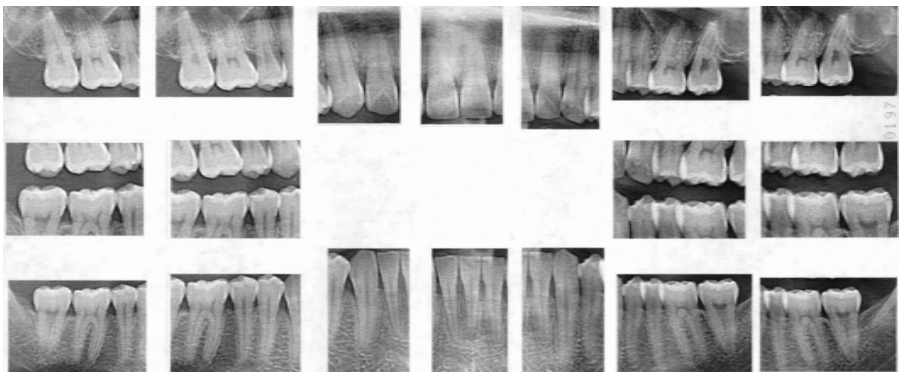
57

Alteration / Falsification of diagnostics



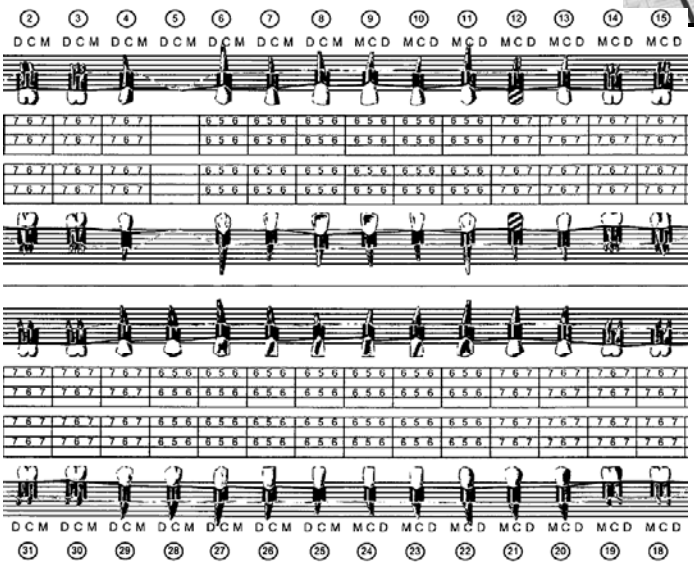
58

Alteration / Falsification of diagnostics



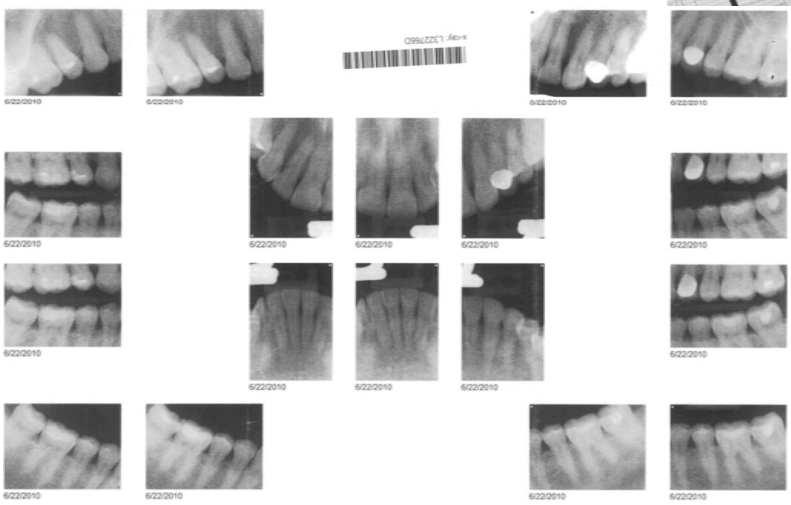
59

Alteration / Falsification of diagnostics



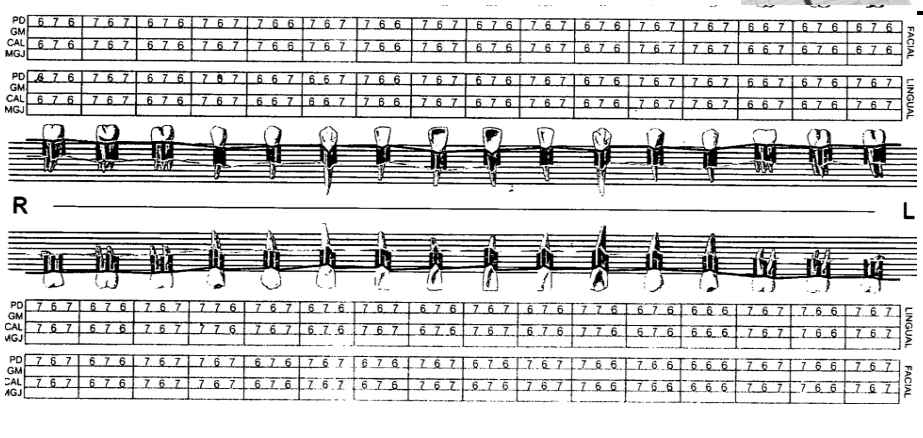
60

Alteration / Falsification of diagnostics



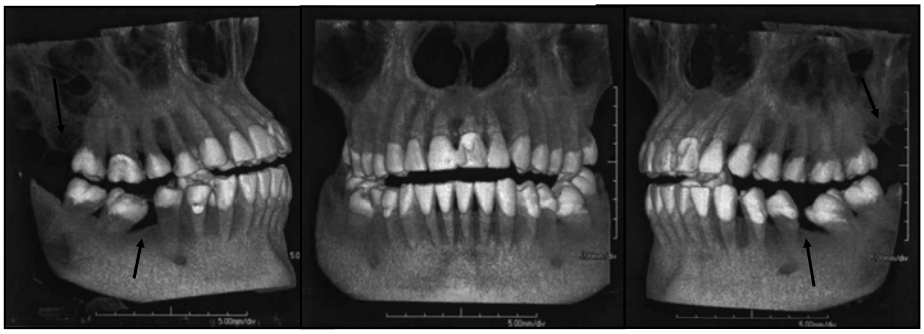
61

Alteration / Falsification of diagnostics



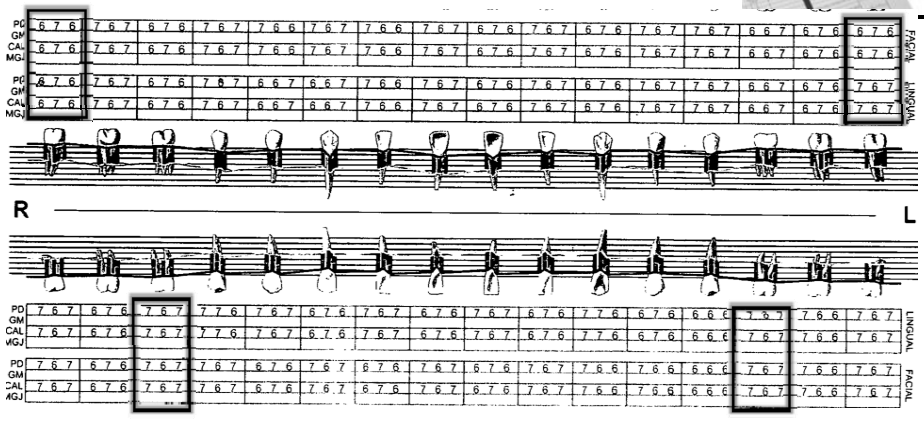
62

Alteration / Falsification of diagnostics



63

Alteration / Falsification of diagnostics



64

Unbundling / Improper use of codes

- To use several codes to describe a service where one code is sufficient is considered a fraudulent act.
  - Need to verify if 'reporting' or unbundling
    - Example: billing for the administration of local anesthetic (CDT 2010/2011 D9215) when a crown procedure is performed

65

Unbundling / Improper use of codes

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	08/08/2009					00274	XRAYS, BITEWING 4	81.00
2	08/08/2009					00230	INTRAORAL PERIAPIC	27.00
3	08/08/2009					00230	INTRAORAL PERIAPIC	27.00
4	08/08/2009					00230	INTRAORAL PERIAPIC	27.00
5	08/08/2009					00230	INTRAORAL PERIAPIC	27.00
6	08/08/2009					00230	INTRAORAL PERIAPIC	27.00
7	08/08/2009					00230	INTRAORAL PERIAPIC	27.00
8	08/08/2009					00120	PERIODIC ORAL EVAL	75.00
9	08/08/2009			14	OL	02392	RESIN COMP 2 SURF	330.00
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent															Primary									
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
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee 648.00

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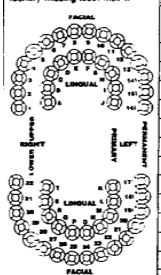
Unbundling / Improper use of codes

21. First visit date current series | 22. Place of treatment: Office, Hosp., ECF, Other | 23. Radiographs or models enclosed? No, Yes | How many? | 29. Is treatment for orthodontics? | If services already commenced enter: | Date appliance placed

Identify missing teeth with "x"



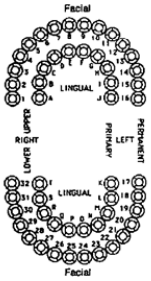
30. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee
			6 21 11	D 0120	125 -
			6 21 11	D 0220	40 -
			6 21 11	D 0230	15 -
			6 21 11	D 0230	15 -
			6 21 11	D 0230	15 -
			6 21 11	D 0230	15 -
			6 21 11	D 0230	15 -
			6 21 11	D 0230	15 -
			6 21 11	D 0274	60 -
	UR		6 21 11	D 4341	130 -
	UL		6 21 11	D 4341	130 -
	LR		6 21 11	D 4341	130 -
	LL		6 21 11	D 4341	130 -

67

Unbundling / Improper use of codes

Identify missing teeth with "X"



30. EXAMINATION AND TREATMENT PLAN -- List in order from tooth no. 1 through tooth no. 32 -- Use charting system shown.

No. or Let.	Surface	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	Date Service Performed MM DD YY	PROCEDURE NUMBER	FEE
		I.V. Sedation-First Half-Hour		D9240	500.00
		I.V. Sedation each additiona 15		D9241	150.00
		I.V. Sedation each additiona 15		D9241	150.00
1		Surg. Extr. of Erupt. Tooth		D7210	250.00
1		Alveoplasty w/ext 1-3 teeth		D7311	175.00
1		Suture of small wounds up to 5cm		D7910	25.00
16		Surg. Extr. of Erupt. Tooth		D7210	250.00
16		Alveoplasty w/ext 1-3 teeth		D7311	175.00
16		Suture of small wounds up to 5cm		D7910	25.00
17		Surg. Extr. of Erupt. Tooth		D7210	250.00
17		Alveoplasty w/ext 1-3 teeth		D7311	175.00
17		Suture of small wounds up to 5cm		D7910	25.00
32		Surg. Extr. of Erupt. Tooth		D7210	250.00
32		Alveoplasty w/ext 1-3 teeth		D7311	175.00
32		Suture of small wounds up to 5cm		D7910	25.00

31. REMARKS FOR UNUSUAL SERVICES

patien in severe pain some swelling and #1,16 are init the sinus cavity #17,32 are on the mandibular ache also causing ache, limited acess.

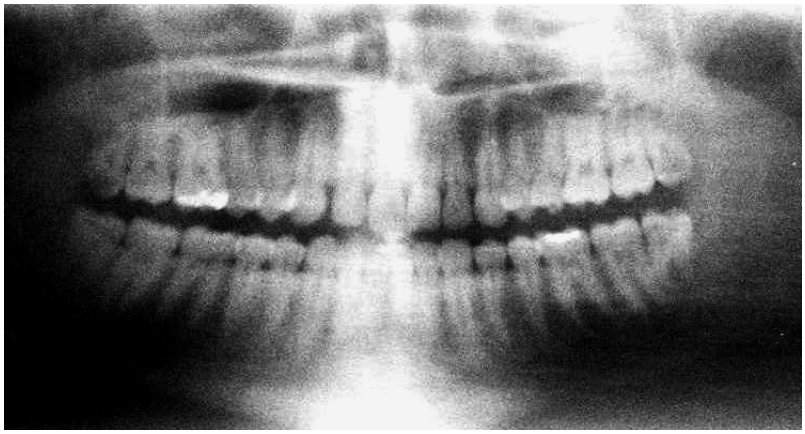
I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

▶ MICHAEL 12/03/07

TOTAL FEE CHARGED 2600.00

68

Unbundling / Improper use of codes



69

Unbundling / Improper use of codes

	24. Procedure Date (MM/DD/CCYY)	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	11-13-2007	8	JP	8		D2950	Core buildup, incl pins	250.00
2	11-13-2007	8	JP	8		D2750	Crown, porc & high noble	930.00
3	11-13-2007		JP			D9630	IRRIGATION	40.00
4	11-13-2007		JP			D9910	App of desensitizing meds	45.00
5	11-13-2007		JP		→	D9951	Occ adj- limtd crn	190.00
6	11-13-2007	9	JP	9		D2950	Core buildup, incl pins	250.00
7	11-13-2007	9	JP	9		D2750	Crown, porc & high noble	930.00
8	11-13-2007		JP			D9630	IRRIGATION	40.00
9	11-13-2007		JP			D9910	App of desensitizing meds	45.00
10								

MISSING TEETH INFORMATION

70

Unbundling / Improper use of codes

1	08-15-2011		JP	19		D2750	Crown, porc & high noble	1,075.00
2	08-15-2011		JP	19	→	D9951	Occ adjustment - limited	150.00
3	08-15-2011		JP	19		D2950	Core buildup, incl pins	330.00
4	08-15-2011		JP	30		D2750	Crown, porc & high noble	1,075.00
5	08-15-2011		JP	30	→	D9951	Occ adjustment - limited	150.00
6	08-15-2011		JP	30		D2950	Core buildup, incl pins	330.00
7	08-15-2011		JP	2		D2750	Crown, porc & high noble	1,075.00
8	08-15-2011		JP	2	→	D9951	Occ adjustment - limited	150.00
9	08-15-2011		JP	2		D2950	Core buildup, incl pins	330.00

71

Unbundling / Improper use of codes

DATE	TOOTH	SURF	CODE	PROCEDURE	CHARGE
08/12/2008	3		D4211	Gingivectomy-1-3 th, per quad	216.00
08/12/2008	4		D4211	Gingivectomy-1-3 th, per quad	216.00
08/12/2008	5		D4211	Gingivectomy-1-3 th, per quad	216.00
				TOTAL:	648.00

72

Unbundling / Improper use of codes

RECORD OF SERVICES PROVIDED

01.02.2009 4 2740 CROWN LAVA FUSED/CR K695.00
01.02.2009 4 9999 ZIRCONIA COPING 595.00

MISSING TEETH INFORMATION

2960.00

ON ORIGINAL CLAIM ZIRCONIA COPING WASN'T BILLED OUT

AUTHORIZATIONS

SIGNATURE ON FILE 01 30 09

SIGNATURE ON FILE 01 30 09

ANCILLARY CLAIM/TREATMENT INFORMATION

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Unbundling / Improper use of codes

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	11/11/2009		JP	7		D2962	Porcelain laminate veneer	540 00
2	11/11/2009		JP	7	→	D2999	Lab fee - metal to porcelain	200 00
3	11/11/2009		JP	8		D2962	Porcelain laminate veneer	540 00
4	11/11/2009		JP	8	→	D2999	Lab fee - metal to porcelain	200 00
5	11/11/2009		JP	9		D2962	Porcelain laminate veneer	540 00
6	11/11/2009		JP	9	→	D2999	Lab fee - metal to porcelain	200 00
7	11/11/2009		JP	10		D2962	Porcelain laminate veneer	540 00
8	11/11/2009		JP	10	→	D2999	Lab fee - metal to porcelain	200 00
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
X	2	3	4	5	6	7	8	9	10	11	12	13	14	15	X	A	B	C	D	E	F	G	H	I	J		
X	31	30	29	28	27	26	25	24	23	22	21	20	19	18	X	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	2960 00

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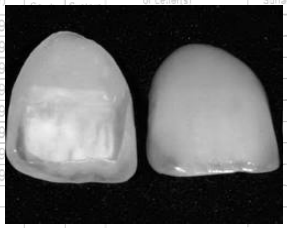
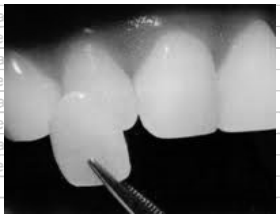
Unbundling / Improper use of codes

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	11/11/2009					D2962	Porcela	540 00
2	11/11/2009					D2999	Lab fee	200 00
3	11/11/2009					D2962	Porcela	540 00
4	11/11/2009					D2999	Lab fee	200 00
5	11/11/2009					D2962	Porcela	540 00
6	11/11/2009					D2999	Lab fee	200 00
7	11/11/2009					D2962	Porcela	540 00
8	11/11/2009					D2999	Lab fee	200 00
9								
10								





MISSING TEETH INFORMATION	Permanent															Primary										32. Other Fee(s)	
34. Place an 'X' on each missing tooth.	X	2	3	4	5	6	7	8	9	10	11	12	13	14	15	X	A	B	C	D	E	F	G	H	I	J		
	X	31	30	29	28	27	26	25	24	23	22	21	20	19	18	X	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	2960 00

35. Remarks

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Unbundling / Improper use of codes

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	11/11/2009		JP	7		D2962	Porcelain laminate veneer	540 00
2	11/11/2009		JP	7	→	D2999	Lab fee - metal to porcelain	200 00
3	11/11/2009		JP	8		D2962	Porcelain laminate veneer	540 00
4	11/11/2009		JP	8	→	D2999	Lab fee - metal to porcelain	200 00
5	11/11/2009		JP	9		D2962	Porcelain laminate veneer	540 00
6	11/11/2009		JP	9	→	D2999	Lab fee - metal to porcelain	200 00
7	11/11/2009		JP	10		D2962	Porcelain laminate veneer	540 00
8	11/11/2009		JP	10	→	D2999	Lab fee - metal to porcelain	200 00
9								
10								

MISSING TEETH INFORMATION	Permanent															Primary										32. Other Fee(s)	
34. Place an 'X' on each missing tooth.	X	2	3	4	5	6	7	8	9	10	11	12	13	14	15	X	A	B	C	D	E	F	G	H	I	J		
	X	31	30	29	28	27	26	25	24	23	22	21	20	19	18	X	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	2960 00

35. Remarks

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Unbundling / Improper use of codes

		Intraoral-periapical-1st film		D0220	21.00
		Add tooth to exist part denture		D5650	850.00
11		Crown-porc fuse high noble mtl		D2750	1500.00
11		Pin retention-/tooth, (+ rest)		D2951	268.00
11		Prefab post&core in add to crn		D2954	209.00
11		Root canal therapy - anterior		D3310	1523.00

77

Unbundling / Improper use of codes

$2306.00 'Prophy'

11.Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code

PLANO.TX 75094

21.Date of Birth (MM/DD/CCYY): 06/06/1975 | 22.Gender: M [X] F | 23.Patient ID/Account # (Assigned by Dentist): 1180881

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	12192007					D4355	FULL MOUTH DEBRIDEMENT	161.00
2	12192007				→	D9210	LOCAL ANESTH/NO SURG PROC.	62.00
3	12192007				UL	D4341	SCALE/ROOT PLANE 4+ TEETH	217.00
4	12192007					D9630	DRUGS AND OR MEDICAMENTS	60.00
5	12192007				LL	D4341	SCALE/ROOT PLANE 4+ TEETH	217.00
6	12192007				→	D4999	PERIODONTAL CHARTING	63.00
7	12192007				→	D9210	LOCAL ANESTH/NO SURG PROC.	62.00
8	12192007				UR	D4341	SCALE/ROOT PLANE 4+ TEETH	217.00
9	12192007					D9630	DRUGS AND OR MEDICAMENTS	60.00
10							CONTINUED ON NEXT PAGE	

MISSING TEETH INFORMATION — 34.(Place an "X" on each missing tooth)

Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Primary: A B C D E F G H I J / T S R Q P O N M L K

32.Other Fee(s)

33.Total Fee: 1119.00

35.Remarks: "Perio Charting" attached X Ray Enclosed

AUTHORIZATIONS

36. I have been informed of the treatment ... fees. I agree to be responsible for all charges for dental servies ... by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual

ANCILLARY CLAIM/TREATMENT INFORMATION

38.Place of Treatment: [X] Provider's Office [ ] Hospital [ ] ECF [ ] Other

39.Number of enclosures (00 to 99)

Page 1

78

Unbundling / Improper use of codes

11.Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code: PLANO.TX 75094

21.Date of Birth (MM/DD/CCYY): 06/06/1975 | 22.Gender: ☐M ☒F | 23.Patient ID/Account # (Assigned by Dentist): 1180881

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	12192007				LR	D4341	SCALE/ROOT PLANE 4+ TEETH	217.00
2	12192007					D4999	PERIODONTAL CHARTING	61.00
3	12192007			02	ML	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
4	12192007			02	DL	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
5	12192007			03	DL	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
6	12192007			03	MF	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
7	12192007			04	DL	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
8	12192007			04	MF	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
9	12192007			13	DV	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
10							CONTINUED ON NEXT PAGE	

MISSING TEETH INFORMATION — 34.(Place an 'X' on each missing tooth)

Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Primary: A B C D E F G H I J / T S R Q P O N M L K

32.Other Fee(s):

33. Total Fee: 1635.00

35.Remarks

Page 2

Unbundling / Improper use of codes

11.Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code: PLANO.TX 75094

21.Date of Birth (MM/DD/CCYY): 06/06/1975 | 22.Gender: ☐M ☒F | 23.Patient ID/Account # (Assigned by Dentist): 1180881

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	12192007			13	ML	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
2	12192007			14	DF	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
3	12192007			14	DL	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
4	12192007			15	MDL	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
5	12192007			15	MF	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
6	12192007			18	DL	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
7	12192007			18	MDL	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
8	12192007			19	DL	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
9	12192007			19	MF	D4381	DELIVER ANTIMICROBIAL AGEN	34.00
10							CONTINUED ON NEXT PAGE	

MISSING TEETH INFORMATION — 34.(Place an 'X' on each missing tooth)

Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Primary: A B C D E F G H I J / T S R Q P O N M L K

32.Other Fee(s):

33. Total Fee: 1941.00

35.Remarks

Page 3

Unbundling / Improper use of codes

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code: PLANO, TX 75094

21. Date of Birth (MM/DD/CCYY): 06/06/1975 | 22. Gender: ☐ M ☒ F | 23. Patient ID/Account # (Assigned by Dentist): 1180881

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	12192007			20	DL	D4381	DELIVER ANTIMICROBIAL AGEN	34 00
2	12192007			20	MF	D4381	DELIVER ANTIMICROBIAL AGEN	34 00
3	12192007			29	ML	D4381	DELIVER ANTIMICROBIAL AGEN	34 00
4	12192007			29	DF	D4381	DELIVER ANTIMICROBIAL AGEN	34 00
5	12192007			30	ML	D4381	DELIVER ANTIMICROBIAL AGEN	34 00
6	12192007			30	DF	D4381	DELIVER ANTIMICROBIAL AGEN	34 00
7	12192007			31	ML	D4381	DELIVER ANTIMICROBIAL AGEN	34 0
8	12192007			31	DF	D4381	DELIVER ANTIMICROBIAL AGEN	34 0
9	12192007					D0120	PERIODIC ORAL EXAM	44 0
10							CONTINUED ON NEXT PAGE	

Page 4

MISSING TEETH INFORMATION

34. (Place an "X" on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
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	2257.00
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

35. Remarks

Page 5

1	12192007															D0274	BITEWINGS FOUR FILMS									49 00	
2																											
3																											
4																											
5																											
6																											
7																											
8																											
9																											
10																											

MISSING TEETH INFORMATION

34. (Place an "X" on each missing tooth)

Permanent																Primary										32. Other Fee	
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	2306.00
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

35. Remarks

Unbundling / Improper use of codes

- Abuse
  - Over treatment
  - Over-use
  - Financial

Unbundling / Improper use of codes

- Abuse

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

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo.	Day	Year	Procedure number	Fee
1		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
3		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
4		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
5		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
6		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
7		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
8		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
9		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
10		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
11		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
12		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
14		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
15		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
17		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
20		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
21		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
22		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
23		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
24		Local delivery of chemo-th B/R	12	08	05	D4381	100.00
25		Local delivery of chemo-th B/R	12	08	05	D4381	100.00

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Unbundling / Improper use of codes

- Abuse

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo	Day	Year	Procedure number	Fee
2		Local delivery of chmo-th B/R				D4381	169.00
3		Local delivery of chmo-th B/R				D4381	169.00
4		Local delivery of chmo-th B/R				D4381	169.00
5		Local delivery of chmo-th B/R				D4381	169.00
12		Local delivery of chmo-th B/R				D4381	169.00
13		Local delivery of chmo-th B/R				D4381	169.00
14		Local delivery of chmo-th B/R				D4381	169.00
19		Local delivery of chmo-th B/R				D4381	169.00
20		Local delivery of chmo-th B/R				D4381	169.00
21		Local delivery of chmo-th B/R				D4381	169.00
27		Local delivery of chmo-th B/R				D4381	169.00
28		Local delivery of chmo-th B/R				D4381	169.00
31		Local delivery of chmo-th B/R				D4381	169.00
32		Local delivery of chmo-th B/R				D4381	169.00

84

Unbundling / Improper use of codes

- Abuse

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo.	Day	Year	Procedure number	Fee
2		Local deliv antimicrb ag-th B/R				D4381	242.00
4		Local deliv antimicrb ag-th B/R				D4381	242.00
5		Local deliv antimicrb ag-th B/R				D4381	242.00
7		Local deliv antimicrb ag-th B/R				D4381	242.00
8		Local deliv antimicrb ag-th B/R				D4381	242.00
14		Local deliv antimicrb ag-th B/R				D4381	242.00
17		Local deliv antimicrb ag-th B/R				D4381	242.00
19		Local deliv antimicrb ag-th B/R				D4381	242.00
24		Local deliv antimicrb ag-th B/R				D4381	242.00

85

Unbundling / Improper use of codes

- Abuse

RECORD OF SERVICES PROVIDED

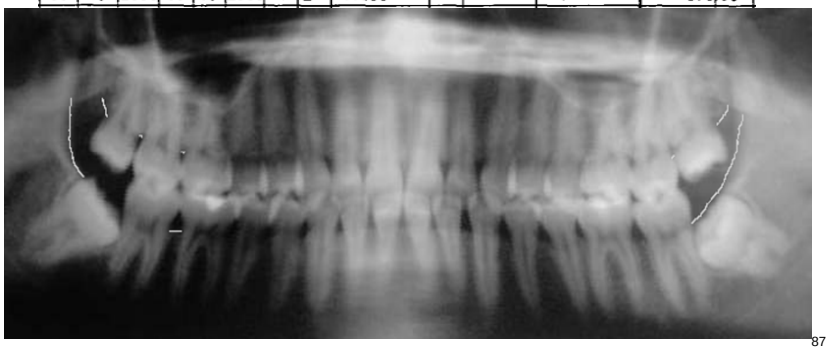
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1			JP	29		D4381	Localized Delivery Of Chemo. Agent	250 00
2			JP	31		D4381	Localized Delivery Of Chemo. Agent	250 00
3			JP	32		D4381	Localized Delivery Of Chemo. Agent	250 00

86

Unbundling / Improper use of codes

Medical / Dental

						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	$ CHARGES
05	15	2008	05	15	2008	11	2	Complete bony impact, #1 41899	1	435.00
05	15	2008	05	15	2008	11	2	Complete bony impact, #16 41899	1	435.00
05	15	2008	05	15	2008	11	2	Complete bony impact, #17 41899	1	435.00
05	15	2008	05	15	2008	11	2	Partial bony impatic, #32 41899	1	375.00



87

Questionable diagnostics

Medical / Dental

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. L 520.6 Disturb. Tooth Eruption
2. L
3. L
4. L

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES
02 15 08	02 15 08	11		Impacted - complete bony, #17 41899	1	425.00
02 15 08	02 15 08	11		Impacted - complete bony, #32 41899	1	425.00
02 15 08	02 15 08	11		IV Sedation 99144	1	395.00
02 15 08	02 15 08	11		Impacted tooth - partial bony, # 41899	1	371.00

25. FEDERAL TAX I.D. NUMBER SSN EIN: 94 ☐ ☒
26. PATIENT'S ACCOUNT NO.: 12 / 74
27. ACCEPT ASSIGNMENT? (For govt. claims, see back): ☐ YES ☒ NO
28. TOTAL CHARGE: $ 1616.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER
32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER

Impacted - complete bony, #17
41899

Impacted - complete bony, #32
41899

IV Sedation
99144

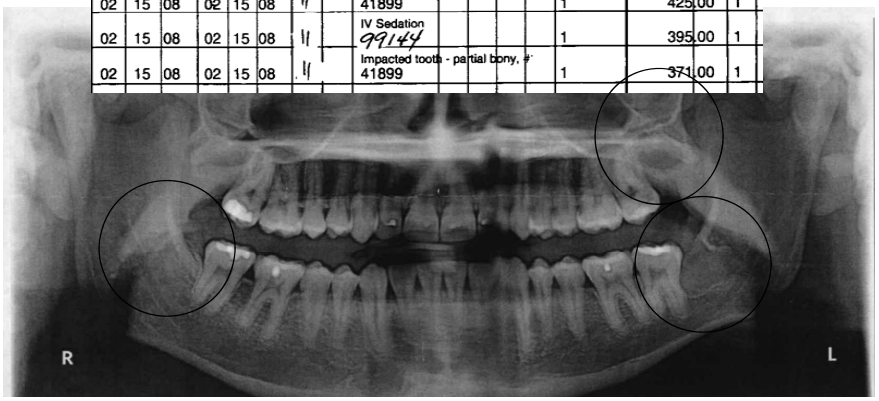
Impacted tooth - partial bony, #
41899

88

Questionable diagnostics

Medical / Dental

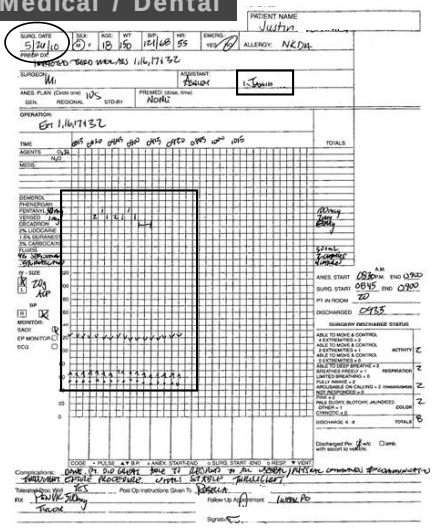
						YY	B Place of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
02	15	08	02	15	08		11		Impacted - complete bony, #17 41899		1	425.00	1
02	15	08	02	15	08		11		Impacted - complete bony, #32 41899		1	425.00	1
02	15	08	02	15	08		11		IV Sedation 99144		1	395.00	1
02	15	08	02	15	08		11		Impacted tooth - partial bony, # 41899		1	371.00	1



89

Alteration of Records

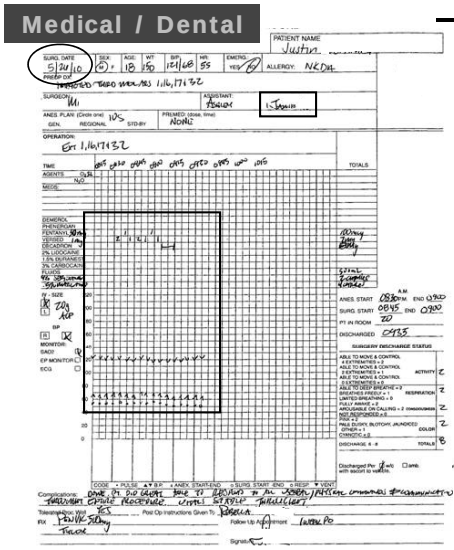
Medical / Dental



90

Alteration of Records

Medical / Dental



August 2, 2010

Patient: Justin (DOB 09/15/1991)
Re: Sedation time limitation

To whom it may concern:

Mr. reported to our office on January 4th, 2010 to address pain and swelling he had been experiencing associated with his maxillary posterior dentition. At this appointment, radiographic and clinical evaluation revealed impacted third molars 1, 16, 17, and 32. Treatment needs of extracting all third molars was reviewed and scheduled.

It was determined that IV Conscious Sedation administration would be needed to comfortably extract all four third molars. Aforementioned treatment was completed on May 26, 2010 with anesthesia beginning at 0830 and completed at 1000 with Mr. able to be safely monitored under the direct supervision of Ashley and Linda a total sedation time of 1 hour and 30 minutes. Please find attached anesthesia record for Mr.

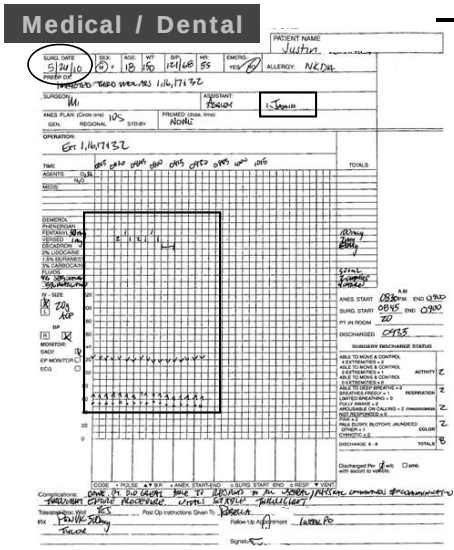
Please contact me at (573) 4 should you have any questions regarding Mr. care and approval for IV Conscious Sedation.

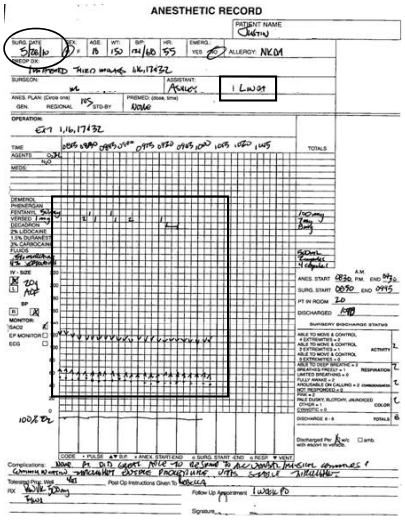
Sincerely,

91

Alteration of Records

Medical / Dental





Alteration of Records

Medical / Dental

To Whom It May Concern:

Enclosed kindly find a medical report for Ms. Ra The report is in the SOAP Narrative format, as recommended by the American Medical Association (AMA). Therefore, it will address patient's subjective condition, objective findings, medical assessment, and associated prognosis.

I would like to thank you for your continued support and cooperation regarding Ms. Ra

Sincerely,

Tom

1st INSURANCE COMPANY PASS ----------
Ra L. 566- - 1-1UG Ins: AETNA Doctor: Tom

Bill 4607	08/08/2008	1	99058-	Emergency Visit (Ex treatment)	$ 150.00
Bill 4607	08/08/2008	1	70210-	Radiologic examination >3views	$ 150.00
Bill 4607	08/08/2008	1	41874-	Alveolarplasty	$ 850.00
Bill 4607	08/08/2008	1	21110-	Periodontal splinting	$ 1,000.00
Bill 4608	08/15/2008	1	99024-	Postoperative follow-up	$ 250.00
Bill 4608	08/15/2008	1	00172-	ANES, INTRA-ORAL	$ 100.00
Bill 4608	08/15/2008	1	97010-	Hot/cold pack	$ 50.00
Bill 4608	08/15/2008	1	95833-	Muscle test body	$ 65.00
Bill 4608	08/15/2008	1	95851-	ROM measurements w/rep	$ 35.00
Bill 4609	08/22/2008	1	99242-	Counsel 50 min, splint removal	$ 200.00
Bill 4609	08/22/2008	1	97139-	Interferential	$ 50.00
Bill 4609	08/22/2008	1	42280-	Prosthesis impression	$ 150.00
Bill 4610	08/29/2008	1	D8680-	Orthodontic Retention (placeme	$ 1,500.00
TOTAL FOR RA L.			13 ITEMS:		$ 4,550.00
TOTAL FOR 1st PASS			13 ITEMS:		$ 4,550.00
TOTAL FOR ALL PASSES			13 ITEMS:		$ 4,550.00

3

Alteration of Records

Medical / Dental

To Whom It May Concern:

Enclosed kindly find a medical report for Mr. Dad . The report is in the SOAP Narrative format, as recommended by the American Medical Association (AMA). Therefore, it will address patient's subjective condition, objective findings, medical assessment, and associated prognosis.

I would like to thank you for your continued support and cooperation regarding Mr. Dad

Sincerely,

Tom

1st INSURANCE COMPANY PASS ----------
Dad P. 563- - 8-1BG Ins: AETNA Doctor: Tom

Bill 4847	11/17/2008	1	99058-	Emergency Visit (Ex treatment)	$ 150.00
Bill 4847	11/17/2008	1	70210-	Radiologic examination >3views	$ 150.00
Bill 4847	11/17/2008	1	41874-	Alveolarplasty	$ 850.00
Bill 4847	11/17/2008	1	21110-	Periodontal splinting	$ 1,000.00
Bill 4848	11/25/2008	1	99024-	Postoperative follow-up	$ 250.00
Bill 4848	11/25/2008	1	00172-	ANES, INTRA-ORAL	$ 100.00
Bill 4848	11/25/2008	1	97010-	Hot/cold pack	$ 50.00
Bill 4848	11/25/2008	1	95833-	Muscle test body	$ 65.00
Bill 4848	11/25/2008	1	95851-	ROM measurements w/rep	$ 35.00
Bill 4849	12/09/2008	1	99242-	Counsel 50 min, splint removal	$ 200.00
Bill 4849	12/09/2008	1	97139-	Interferential	$ 50.00
Bill 4849	12/09/2008	1	42280-	Prosthesis impression	$ 150.00
Bill 4850	12/16/2008	1	D8680-	Orthodontic Retention (placeme	$ 1,500.00
TOTAL FOR DAD P.			13 ITEMS:		$ 4,550.00
TOTAL FOR 1st PASS			13 ITEMS:		$ 4,550.00
TOTAL FOR ALL PASSES			13 ITEMS:		$ 4,550.00

Unbundling / Improper use of codes

- Fragmenting
  - Fragmenting is a practice similar to **unbundling.**
  - The procedures and/or services are not necessarily performed on the same day and are may still be considered to be in the global period.
  - Separate claims are submitted for each procedure that makes up the major procedure on different dates of service.

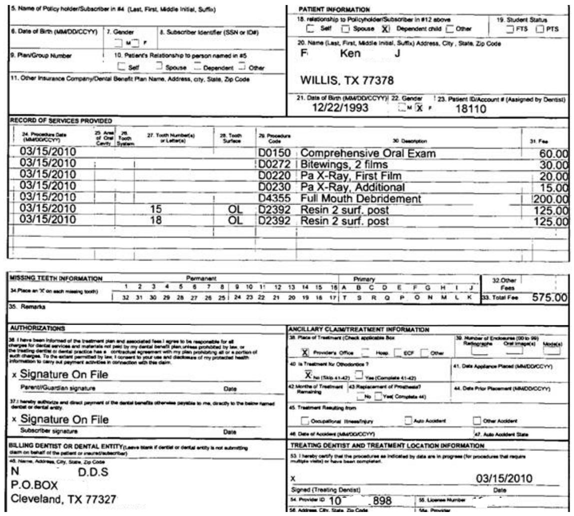
95

Non-Claim Review Related Areas of Fraud

- Non-Claim Review Related
  - Misrepresenting patient identities
  - Not disclosing existence of additional or primary coverage
  - Waiver of co-payments and/or deductibles

96

Misrepresenting patient identities



5. Name of Policy holder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 above: X Dependent child

20. Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code

F Ken J

WILLIS, TX 77378

21. Date of Birth (MM/DD/CCYY): 12/22/1993 | 22. Gender: X F | 23. Patient ID/Account # (Assigned by Dentist): 18110

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
03/15/2010			D0150	Comprehensive Oral Exam	60.00
03/15/2010			D0272	Bitewings, 2 films	30.00
03/15/2010			D0220	Pa X-Ray, First Film	20.00
03/15/2010			D0230	Pa X-Ray, Additional	15.00
03/15/2010			D4355	Full Mouth Debridement	200.00
03/15/2010	15	OL	D2392	Resin 2 surf. post	125.00
03/15/2010	18	OL	D2392	Resin 2 surf. post	125.00

33. Total Fee: 575.00

AUTHORIZATIONS

x Signature On File

x Signature On File

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: X Provider's Office

40. Is Treatment for Orthodontics? X No

BILLING DENTIST OR DENTAL ENTITY

N D.D.S

P.O.BOX

Cleveland, TX 77327

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

x 03/15/2010

54. Provider ID 10 898

97

Misrepresenting patient identities

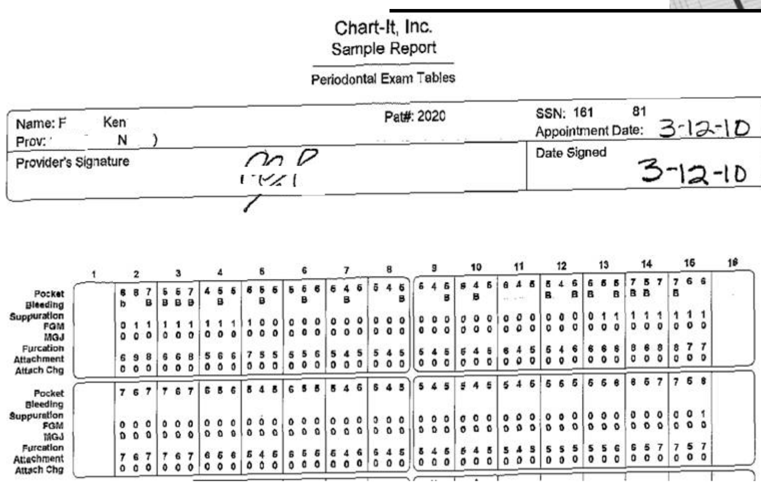


Chart-It, Inc.

Sample Report

Periodontal Exam Tables

Name: F Ken | Pat#: 2020 | SSN: 161 81

Prov: N)

Appointment Date: 3-12-10

Provider's Signature

Date Signed 3-12-10

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

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Misrepresenting patient identities

Chart-It, Inc.
Sample Report

Periodontal Exam Tables

Name: F Kea
Prov: N
Pat#: 2020
SSN: 161 81
Appointment Date: 3-12-10

Provider's Signature

Date Signed 3-12-10

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

99

Misrepresenting patient identities

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Sample Report

Periodontal Exam Tables

Name: F Keel
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	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket		6 8 7	5 5 7	4 5 5	6 5 5	5 5 6	5 4 5	5 4 5	5 4 5	6 4 5	6 4 5	5 4 6	6 5 5	7 5 7	7 6 6	
Bleeding		b B	B B B	B	B	B	B	B	B	B		B B	B B	B B	B	
Suppuration																
FGM		0 1 1	1 1 1	1 1 1	1 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 1 1	1 1 1	1 1 1	
MGJ		0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	
Furcation																
Attachment		6 9 8	6 6 8	5 6 6	7 5 5	5 5 6	5 4 5	5 4 5	5 4 5	6 4 5	6 4 5	5 4 6	6 6 6	8 6 8	8 7 7	
Attach Chg		0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	
Pocket		7 6 7	7 6 7	6 5 6	5 4 5	6 5 5	5 4 6	6 4 5	5 4 5	5 4 5	5 4 5	5 5 5	5 5 6	6 5 7	7 5 6	
Bleeding																
Suppuration																
FGM		0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 1	
MGJ		0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	
Furcation																
Attachment		7 6 7	7 6 7	6 5 6	5 4 5	6 5 5	5 4 6	6 4 5	5 4 5	5 4 5	5 4 5	5 5 5	5 5 6	6 5 7	7 5 7	
Attach Chg		0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	

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Misrepresenting patient identities

- Performing treatment on patient and submitting a claim for that person as someone else is fraud.

101

Not disclosing existence of additional or primary coverage

- Deliberate submission to different carriers without disclosure of additional or identification of primary or secondary coverage status to obtain benefits as if each were the primary carrier, is a fraudulent act
- Covered patients may receive benefits from more than one dental plan provided each plan knows about the other.

102

Waiver of Co-payments and/or Deductibles

- Waiving of co-payments may encourage more usage of the coverage than would normally occur
- Waiving of deductibles may encourage more usage of the coverage than would normally occur
  - Co-payments and deductibles are considered to be an essential element of the contract the cost structure
- Skews the cost structure of the contract between the purchaser and the Third Party Payer
  - Co-payment and Deductibles, by contract, are to be collected

103

Time for a few questions before closing. . .

104

Dental Fraud:
The Claim Review Perspective

- Summary
  - Opportunities for fraudulent activity in the Dental industry exist
  - Detection of fraudulent or suspicious activity through the claim review perspective can aid in a through investigation

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Dental Fraud:
The Claims Review Perspective

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