BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

In The Matter Of:	)	
	)	FINAL AGENCY
SASSAN BASSIRI, D.D.S.	)	DECISION
(License No. 7705)	)	

THIS MATTER was heard before the North Carolina State Board of Dental Examiners (Board) on November 5 - 6 and December 3 - 5, 2010 pursuant to N.C. Gen. Stat. §§ 90-41.1 and 150B-38 and 21 NCAC 16N .0504 of the Board's Rules. The Board's Hearing Panel consisted of Board members Dr. Ronald K. Owens, presiding; Dr. Brad C. Morgan, Dr. Millard W. Wester, III, Dr. Kenneth M. Sadler and Dr. David A. Howdy. Board members Dr. C. Wayne Holland, Ms. Jennifer Sheppard and Dr. James B. Hemby, Jr., did not participate in the hearing, deliberation or decision of this matter. The Respondent, Dr. Sassan Bassiri (Respondent), was represented by Steven M. Shaber and Chris P. Brewer. Carolin Bakewell represented the Investigative Panel and Thomas F. Moffitt represented the Hearing Panel.

Based upon the stipulations of the parties and the evidence produced at the hearing, the Board enters the following:

FINDINGS OF FACT

1. The Dental Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding pursuant to the authority granted to it in Chapter 90 of the North Carolina General Statutes, including the Dental Practice Act and the Rules and Regulations of the North Carolina State Board of Dental Examiners.

2. The Respondent was licensed to practice dentistry in North Carolina on September 17, 2003 and holds license number 7705.

3. At all times relevant hereto, the Respondent was subject to the Dental Practice Act and the Board's rules and regulations promulgated thereunder.

4. The Respondent was properly served with the pleadings in this matter and had notice of the hearing dates.

RESPONDENT'S ABILITY TO UNDERSTAND THE ENGLISH LANGUAGE

5. The Respondent is not a native born American. He immigrated to the United States in 1986 at the age of 18. When he arrived, he already spoke English. In 1987, the Respondent enrolled at Southern A&M University, where he took classes in English and was sufficiently proficient in English to successfully complete courses in calculus, chemistry and physics.

6. In 1988, the Respondent enrolled at N.C. State University, where he took more courses in English and tutored other students in mathematics and physics. The Respondent graduated from N.C. State University with a degree in electrical engineering. While enrolled at N.C. State, he was employed as an engineering assistant for two companies, and after graduation he worked as a test engineer for a company named QMD.

7. The Respondent enrolled and graduated from the Dental School at the University of North Carolina at Chapel Hill, where all of the courses are taught in English, and he was able to pass the North Carolina Board Examination, which is given in English.

8. The Respondent has sufficient knowledge and understanding of the English language to be able to understand the requirements applicable to all dentists licensed in this State, including the Board's rules and the rules applicable to dentists who treat Medicaid patients and seek payment for their services under applicable Medicaid rules.

FRAUDULENT BILLING OF EXAMINATION CHARGES

9. The Respondent became an approved dental provider for the North Carolina Division of Medical Assistance (DMA) in November 2003.

10. Pursuant to his contract with DMA, the Respondent was required to abide by all DMA billing guidelines, ensure that his invoices were accurate, and submit timely corrections of any erroneous invoices.

11. DMA uses the coding system set out in the American Dental Association Current Dental Terminology (CDT) Manual. The CDT coding system is also widely used by private insurance companies and by the University of North Carolina School of Dentistry.

12. At all times relevant hereto, the CDT Manual defined Code D0160, in pertinent part, as "a detailed and extensive problem focused evaluation entail[ing] extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented."

13. At all times relevant hereto, the CDT Manual defined Code D0120, in pertinent part, as a "periodic oral evaluation of an established patient," defined Code

D0140 as an "evaluation limited to a specific oral health problem or complaint" and defined Code D0150 as a "comprehensive oral evaluation."

14. DMA has consistently reimbursed providers at a higher rate for performing a Code D0160 evaluation than for a Code D0120, D0140 or D0150 evaluation.

15. Beginning in December 2003 and continuing through at least the end of 2009, the Respondent, or his staff acting at his direction, knowingly and fraudulently used Code D0160 to bill DMA for routine and recall visits that should have been charged as a lower paying code, such as D0120, D0140 or D0150.

16. For example, Patient G.B. identified in the Investigative Panel's Notice of Hearing presented to the Respondent's dental office on August 13, 2008, at which time the Respondent made impressions for an upper partial and his staff provided scaling and root planing treatment. On September 8, 2008, the Respondent delivered G.B.'s partial denture. On January 26, 2009, G.B. returned to the Respondent's practice for an adult prophylaxis. Respondent improperly billed each of these visits as a Code D0160 examination.

17. Neither the Respondent nor his staff revealed to DMA that the appointments billed as Code D0160 evaluations were not "detailed and extensive evaluations" or that the appointments should have been billed pursuant to a lower paying code.

18. Between December 2003 and the end of 2009, Respondent improperly used Code D0160 approximately 19,000 times, for which he collected approximately $1 million from DMA.

19. Although the Respondent claimed that an unidentified employee of Electronic Data Systems (EDS), then the fiscal agent for DMA, advised him in December 2003 to use Code D0160 for all patient visits, the Respondent presented no credible evidence that such advice was ever given.

20. The EDS representative in charge of training for the Respondent's area of the state in 2003 denied that he advised the Respondent or his staff to bill Code D0160 for routine office visits. Such advice would have directly contradicted the CDT Manual and DMA policy. The Hearing Panel found the EDS representative's testimony to be credible.

21. The Respondent's claim that he believed it was proper to use Code D0160 for all Medicaid patient visits as of late 2003 is contradicted by the Respondent's billing records. Those records show that the Respondent often billed DMA for routine office visits using Codes D0120, D0140 and D0150 long after December 2003.

22. Telephone calls placed by the Respondent and his office manager, Pam Badgett (Ms. Badgett) to EDS beginning in October 2008 demonstrate that the Respondent knew he had been misusing Code D0160.

23. On October 23, 2008, just days after he learned that he was under investigation by the Dental Board, the Respondent directed Ms. Badgett to call EDS regarding the use of Code D0160.

24. During the October 23, 2008 call, an EDS employee named Amy told Ms. Badgett that Code D0160 could not be used for routine office visits and advised Ms. Badgett to read the DMA policy manual.

25. Ms. Badgett told the Respondent about her conversation with Amy.

26. On four other occasions in May and December 2009, the Respondent again directed Ms. Badgett to telephone EDS about Code D0160. During one of the calls, on May 5, 2009, the Respondent personally spoke to an EDS representative about Code D0160.

27. During the calls to EDS, Ms. Badgett and the Respondent inquired only whether Code D0160 was "payable" or "legitimate" or could be billed daily, rather than asking under what circumstances the code could properly be used. The Respondent carefully structured these inquiries to elicit responses that he could produce to justify his use of Code D0160 or, at the least, bolster an argument that he was confused about the subject.

28. Respondent continued to mischaracterize Medicaid patients' routine office visits as Code D0160 evaluations until late 2009.

29. The Respondent, or his staff acting at his direction, intentionally and fraudulently misused Code D0160 for the improper purpose of increasing the amount of the fees collected from DMA.

30. DMA paid the Respondent for performing Code D0160 evaluations in reliance upon his misrepresentations regarding the nature of the examination performed.

FRAUDULENT BILLING OF SCALING AND ROOT PLANING

31. On numerous occasions between 2004 and 2009, the Respondent, or his staff acting at his direction, knowingly and fraudulently billed DMA for performing four quadrants of scaling and root planing (SRP) when in fact his staff had not performed four quadrants of SRP.

32. For example, Patient V.M. testified that her February 13, 2008 scaling and root planing appointment lasted only about 30 minutes. V.M. denied that the Respondent or his hygienist used any sort of instrument to deep clean along the roots of her teeth. According to her, the visit was like a routine prophylaxis appointment. The Hearing Panel found Patient V.M.'s testimony to be credible.

33. The Respondent, or his staff acting at his direction, intentionally and fraudulently billed DMA for performing four quadrants of SRP during V.M.'s February 13, 2008 appointment.

34. Leah Handy, a hygienist who formerly worked for the Respondent, testified that about one half of the Respondent's patients who were scheduled for SRP did not require the treatment and in fact, got a prophylaxis. The Hearing Panel found Ms. Handy's testimony to be credible.

35. The Respondent typically limited SRP appointments to 45 minutes, even though his hygiene staff complained that this was not enough time to properly complete four quadrants of SRP.

36. Proper scaling and root planing involves instrumenting the crown and root surfaces of the tooth to remove calculus and plaque. It is indicated for patients with periodontal disease and is a therapeutic, not a preventive treatment. It would be very

difficult, if not impossible, for a hygienist to properly complete four quadrants of SRP in less than an hour.

37. DMA has consistently paid more for four quadrants of SRP than for a prophylaxis or fewer than four quadrants of SRP.

38. The fact that DMA gave prior approval for the SRP procedures for which the Respondent later billed the agency does not prove that Respondent or his staff actually performed the work or even that SRP was medically necessary for any patient.

39. Before October 2009, DMA staff did not attempt to diagnose the periodontal condition of patients for whom pre-approval for SRP was sought. Instead, DMA relied on the individual providers to make the appropriate diagnosis.

40. Before October 2009, DMA required providers only to submit a panoramic radiograph to support a request for prior approval of SRP. Panoramic radiographs typically are not diagnostic for periodontal disease. The radiographs were used by DMA staff only to determine if the patient had the requisite number of teeth per quadrant to qualify for reimbursement of the SRP procedure.

41. Even after October 2009, when DMA began requiring practitioners to submit charts of periodontal probing depths to support requests for approval of SRP procedures, DMA did not require proof after the fact that the procedures had actually been performed.

42. The Respondent, or his staff acting at his direction, intentionally and fraudulently misrepresented the kind of treatment performed at SRP appointments for the improper purpose of increasing the amount of the fees collected from DMA.

43. DMA paid the Respondent for performing four quadrant scaling and root planing in reliance upon his misrepresentations concerning the scope and nature of the work performed.

FRAUDULENT BILLING FOR FILLINGS

44. On numerous occasions between at least 2006 and 2009, the Respondent, or his staff acting on his direction, knowingly and fraudulently billed DMA for placing two separate fillings on the same tooth when in fact he had performed only a single filling with multiple surfaces.

45. For example, the patient treatment records for Patient J.S., included in Investigative Panel Exhibit 20, state that the Respondent performed a tooth # 4 MOD (mesial-occlusal-distal) filling on July 27, 2009. Nevertheless, the Respondent or his staff billed DMA for performing two separate fillings: #4 D and #4 MO during Patient J.S.'s July 27, 2009 appointment.

46. As a further example, the treatment records for Patient V.M., included in Investigative Panel Exhibit 57, state that the Respondent performed a #31 MODBL (mesial-occlusal-distal-buccal-lingual) filling and a # 29 MOD filling on October 24, 2006. Nevertheless, the Respondent or his staff acting at his instruction billed DMA for performing four separate fillings: #31 MOD, # 31 BL, #29 MO and #29 D during V.M.'s October 24, 2006 appointment.

47. DMA has consistently paid more for two separate fillings than for a single filling, even if the same number of surfaces were restored. Consequently, a bill for #10 MO and tooth #10 D fillings would yield a higher fee than a bill for a # 10 MOD filling.

48. Although the Respondent claimed that he received a code sheet from DMA in late 2003 that he believed permitted him to bill DMA for two separate fillings when he had completed only a single filling, there is no credible evidence supporting this claim.

49. The directive identified by the Respondent cannot reasonably be read to permit a DMA provider to inflate the scope of the restorative work performed, particularly when such an interpretation would significantly increase the fees paid by DMA to the provider.

50. The Respondent's claim that he had a good faith belief by late 2003 that he could always bill a single filing with multiple surfaces as two separate fillings is also contradicted by his billing records.

51. For example, although the Respondent began dividing multiple surface single fillings into two separate restorations for DMA billing purposes in December 2003, his billing practices were not consistent. Respondent often billed DMA properly for performing multiple surface single fillings until late 2009. Further, Respondent properly billed multiple surface single fillings performed on patients who had no insurance or who had private insurance coverage.

52. Neither the Respondent nor his staff disclosed to DMA when they billed DMA for completing two separate fillings but in fact only one filling with multiple surfaces had been performed.

53. The Respondent, or his staff acting at his direction, intentionally and fraudulently billed DMA for performing two separate fillings on a single tooth when in

fact he had placed a single filling with multiple surfaces, for the improper purpose of increasing the amount of the fees collected from DMA.

54. DMA paid the Respondent for performing two separate fillings on the same tooth in reliance upon his misrepresentations about the scope of the restorations that had been performed.

FRAUDULENT BILLING OF FULL MOUTH DEBRIDEMENT

55. On a number of occasions, the Respondent or his staff acting at his direction, knowingly and fraudulently billed DMA for a full mouth debridement when in fact only a prophylaxis was performed.

56. CDT Code D4355 defines a full mouth debridement, in pertinent part, as "[t]he gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation . . .."

57. CDT Code D1110 defines as "a dental prophylaxis performed on transitional or permanent dentition that includes scaling and/or polishing procedures to removal coronal plaque, calculus and stains."

58. DMA has consistently paid more for a full mouth debridement than for a prophylaxis.

59. In some instances, the Respondent billed DMA for performing a full mouth debridement even though his treatment records indicate that only a prophylaxis was performed. For example, the records for Patient B.W., included in Respondent's Exhibit 225, indicate that B.W. received a prophylaxis on March 22, 2004. Nevertheless, the Respondent or his staff billed DMA for performing a full mouth debridement during B.W.'s March 22, 2004 appointment.

60. In other cases, the Respondent billed DMA for performing a full mouth debridement when the patient treatment record indicates that the patient had good home care and there was nothing to interfere with the Respondent's ability to conduct an examination. For example, the Respondent billed DMA for performing a full mouth debridement on Patient V.M. on August 6, 2008. The patient treatment record, included in the Investigative Panel's Exhibit 57, reported that V.M. had good home care and minimal calculus and plaque as of August 6, 2008.

61. The Respondent claimed that he did not understand the distinction between a full mouth debridement and a prophylaxis and therefore thought it was proper to bill for a full mouth debridement when a prophylaxis had been performed. The Respondent presented no credible evidence to support this claim.

62. The distinction between a full mouth debridement and a prophylaxis is easy to grasp by a dentist and was understood by the Respondent's auxiliaries, who did not have the benefit of Respondent's dental education or his years of experience as a dentist.

63. The Respondent's claim that he was confused about the distinction between prophylaxes and full mouth debridement is contradicted by the fact that he properly billed for prophylaxes performed for patients who had private insurance or no dental insurance.

64. The Hearing Panel also finds that it is significant that the Respondent never billed DMA for performing a prophylaxis when he had performed the more expensive full mouth debridement procedure. The Respondent's alleged confusion

about the distinction between a prophylaxis and full mouth debridement always worked in a way that benefited him financially.

65. The Respondent, or his staff acting at his direction, intentionally and fraudulently billed DMA for performing full mouth debridements when only prophylaxes had been performed for the improper purpose of increasing the amount of the fees collected from DMA.

66. Neither the Respondent nor his staff revealed that he had billed DMA for performing a full mouth debridement when in fact only a prophylaxis had been performed.

67. DMA paid the Respondent for performing full mouth debridements in reliance upon his misrepresentation about the nature of the treatment provided.

FRAUDULENT UPCODING FOR ALVEOLOPLASTIES

68. On numerous occasions the Respondent, or his staff acting at his direction, knowingly and fraudulently billed DMA for performing alveoloplasties in conjunction with the extraction of four or more teeth per quadrant, when in fact the Respondent had extracted fewer than four teeth per quadrant.

69. Code D7310 should be used to bill for alveoloplasties performed following the extraction of four or more teeth per quadrant. Code D7311 should be used to bill for alveoloplasties performed following the extraction of fewer than four teeth per quadrant.

70. DMA has consistently paid practitioners more for Code D7310 than Code D7311 alveoloplasties. Before January 1, 2007, DMA did not reimburse practitioners

any amount for performing alveoloplasties following the extraction of fewer than four teeth per quadrant.

71. The Respondent billed DMA for performing Code D7310 alveoloplasties in conjunction with the extraction of four or more teeth per quadrant for patients GB, JB, AB, JB, MB and AH, as alleged in the Notice of Hearing. In each case, the Respondent had in fact extracted fewer than four teeth per quadrant and was entitled to no compensation or, at most, a lower rate of compensation pursuant to Code D7311.

72. The Respondent claimed that he was confused about the appropriate CDT code for alveoloplasties but presented no credible evidence to support his claim.

73. The Respondent used CDT codes while in dental school and was able to discuss a number of the codes in detail in response to direct and cross examination questions during the trial of this matter.

74. The Respondent's staff was also knowledgeable about CDT codes. Ms. Badgett was familiar with dental insurance coding and billing from her prior employment in the office of another dentist. The Respondent's staff accessed DMA's website for information about reimbursement rates and coverage. A copy of the DMA Policy Manual, which contained descriptions of the CDT code procedures, was kept at the front desk area of the Respondent's practice and summaries of some DMA coverage policies were posted in the Respondent's operatories.

75. The Respondent, or his staff acting at his direction, intentionally and fraudulently overstated the number of extractions that had been performed in association with the alveoloplasties for the improper purpose of increasing the amount of the fees collected from DMA.

76. Neither the Respondent nor his staff disclosed to DMA that he had overstated the number of extractions performed when he improperly billed for Code D7310 alveoloplasties.

77. DMA paid the Respondent for performing Code D7310 alveoloplasties in reliance upon his misrepresentations about the scope of the work performed.

FRAUDULENT BILLING FOR MEDICALLY UNNECESSARY ALVEOLOPLASTIES

78. Between 2004 and 2009, the Respondent routinely performed and billed DMA for medically unnecessary alveoloplasties following the extraction of a single tooth.

79. For example, during January 2008, the Respondent billed DMA for performing alveoloplasties after at least 37 single-tooth extractions. The patients were not scheduled to receive a prosthesis. It is rarely medically necessary for a dentist to perform an alveoloplasty after a single-tooth extraction, except when the patient is about to receive a dental prosthesis. The Respondent did not routinely bill private insurance companies for performing alveoloplasties after single-tooth extractions.

80. DMA has consistently paid more for a single tooth extraction accompanied by an alveoloplasty than a single tooth extraction performed without an alveoloplasty.

81. The Respondent performed the unnecessary alveoloplasties for the improper purpose of increasing the fees that he collected from DMA.

82. The Respondent, or his staff acting at his direction, knowingly and fraudulently billed DMA for performing medically unnecessary alveoloplasties without revealing that the procedures were not medically necessary.

83. DMA would not have reimbursed the Respondent had it been aware that the alveoloplasties were unnecessary. DMA paid the Respondent for performing

alveoloplasties in reliance on his misrepresentation regarding the medical necessity of the procedures.

84. The standard of care applicable to North Carolina dentists between 2004 and 2009 forbade dentists from performing medically unnecessary procedures, including alveoloplasties.

85. The Respondent violated the standard of care applicable to North Carolina dentists by performing medically unnecessary alveoloplasties.

FRAUDULENT BILLING OF SURGICAL EXTRACTION CODE

86. As of September 2008, A.H. was a patient of the Respondent's dental practice. At all times relevant hereto, A.H. was eligible for Medicaid.

87. On September 17, 2008, Respondent performed a simple extraction of A.H.'s tooth number 19. The tooth had no attachment to the bone and did not require a surgical extraction.

88. The Respondent or his staff acting at his direction knowingly and fraudulently represented to DMA that the Respondent had surgically extracted A.H.'s tooth number 19, without disclosing that the tooth had almost no attachment to the bone and did not require a surgical extraction.

89. DMA has consistently paid more for surgical extractions than for non-surgical extractions.

90. The Respondent, or his staff acting at his direction, intentionally and fraudulently misused the surgical extraction code for the improper purpose of increasing the amount of the fees collected from DMA.

91. DMA paid the Respondent for surgically extracting A.H.'s tooth number 19 in reliance upon his misrepresentation about the nature of the extraction.

FRAUDULENT BILLING OF ROUTINE EXTRACTION
PATIENT J.D.

92. As of July 17, 2008, J.D. was a patient of the Respondent's practice. At all times relevant hereto, J.D., who was then a minor, was eligible for Medicaid.

93. The Respondent extracted J.D.'s primary tooth D on July 17, 2008.

94. J.D.'s tooth D had nearly exfoliated as of July 17, 2008.

95. DMA has consistently declined to pay for extractions of primary teeth on the verge of exfoliation.

96. On or shortly after July 17, 2008, the Respondent or his staff acting at his direction, knowingly and fraudulently billed DMA for extracting J.D.'s tooth D, without disclosing that the tooth was about to exfoliate.

97. The Respondent, or his staff acting at his direction, intentionally and fraudulently billed DMA for extracting J.D.'s tooth D without revealing that the tooth was about to exfoliate for the improper purpose of increasing the amount of the fees collected from DMA.

98. DMA reimbursed the Respondent for extracting J.D.'s tooth D in reliance upon the Respondent's failure to disclose that the tooth had nearly exfoliated as of July 17, 2008.

NEGLIGENT FAILURE TO DIAGNOSE DECAY
PATIENT H.B.

99. On October 18, 2006, Patient H.B., who was then six years old, presented to the Respondent's dental office. At all times relevant hereto, H.B. was eligible for Medicaid.

100. Bitewing radiographs taken by the Respondent's staff on October 18, 2006 showed decay on H.B's teeth A, B, I, J, L, S and T.

101. The Respondent did not detect the decay on H.B.'s teeth A, I, J, L, S or T, nor did he note the existence of the decay in HB's treatment record for the October 18, 2006 visit. Instead, the Respondent directed his dental assistant to place sealants on 12 of H.B.'s teeth, including A, I, J and T.

102. The standard of care applicable to North Carolina dentists in 2006 required dentists to promptly detect and accurately note radiographically discernible decay in the patient treatment record.

103. The Respondent violated the standard of care applicable to North Carolina dentists in 2006 by failing to promptly detect decay on H.B's teeth A, I, J, L, S and T and by failing to accurately note the decay in H.B.'s treatment record following her October 18, 2006 visit.

104. The standard of care applicable to North Carolina dentists in 2006 forbade dentists from directing their staff to seal teeth with existing decay.

105. The Respondent violated the standard of care applicable to North Carolina dentists in 2006 by directing his staff to apply sealants to H.B.'s teeth A, I, J and T.

NEGLIGENT PLACEMENT OF SEALANTS
PATIENT C.B.

106. On March 5, 2008, Patient C.B., who was then a minor, presented to the Respondent's dental office for treatment. At all times relevant hereto, C.B. was eligible for Medicaid.

107. The Respondent directed an assistant to apply sealants to C.B.'s teeth numbers 2, 3, A, 5, 12, 14, 15, 18, 19, 21, 28, 30 and 31 during the March 5, 2008 visit.

108. The Respondent failed to ensure that the sealants were properly applied.

109. Properly applied sealants ordinarily can be expected to last three to five years.

110. On September 10, 2008, within six months of the original application of the sealants, C.B. returned to the Respondent's office, at which time a second set of sealants were applied to C.B.'s teeth numbers 2 – 5, 12, 14, 15, 18 – 21, and 28 – 30.

111. The standard of care applicable to North Carolina dentists in 2008 required dentists to ensure that all sealants were properly applied by staff under their supervision.

112. The Respondent violated the standard of care applicable to North Carolina dentists by failing to ensure that his staff properly applied sealants to C.B.'s teeth at the March 5, 2008 visit.

In addition to the foregoing findings of fact relating to allegations set out in the Notice of Hearing in this matter, the Board also makes the following:

ADDITIONAL FINDINGS OF FACT REGARDING DISHONEST INTENT

113. On a number of occasions, the Respondent directed his dental assistants to apply sealants to teeth that Respondent knew had existing decay or that were about to exfoliate.

114. DMA has consistently refused to reimburse providers for applying sealants to teeth that had existing decay or were about to exfoliate.

115. The Respondent or his staff, acting at his direction, knowingly and fraudulently billed DMA for sealing teeth that had existing decay or were about to exfoliate.

116. For example, Frankie Parker, a long-time dental assistant formerly employed by the Respondent, testified that the Respondent directed his staff to place sealants on teeth that were decayed or about to exfoliate. Ms. Leah Handy and Ms. Laura Hill, hygienists formerly employed by the Respondent, also testified that the Respondent directed staff to apply sealants to primary teeth that were about to exfoliate. The Hearing Panel finds the testimony of Ms. Parker, Ms. Hill and Ms. Handy to be credible.

117. The Investigative Panel also presented evidence from the Respondent's treatment records demonstrating that the Respondent directed staff to apply sealants to patients' teeth with existing decay. For example, Investigative Panel Exhibit 97 reflects that Respondent's staff sealed tooth #13 of Brittany A. on September 18, 2008. Five days later, on September 23, 2008, Brittany A returned to the Respondent's practice, at which time Respondent performed a #13 DO filling.

118. Neither the Respondent nor his staff revealed to DMA that sealants had been applied to teeth with existing decay or that were about to exfoliate.

119. DMA paid Respondent for applying sealants to teeth with decay or that were about to exfoliate in reliance on his misrepresentations.

120. On a number of occasions, the Respondent knowingly and fraudulently billed DMA for fillings that were not performed as represented.

121. For example, Patient Crystal M. presented to the Respondent's dental office on October 2, 2008, at which time the treatment record, included in Investigative Panel Exhibit 28 , shows that the Respondent performed two fillings with a total of four surfaces: #7 ML and #8 ML. Thereafter, however, the Respondent or his staff acting at his direction, knowingly and fraudulently billed DMA for performing four separate fillings with a total of six surfaces: #7 L, #7 MF, #8F, #8ML.

122. Neither the Respondent nor his staff revealed to DMA that the fillings had not been performed as represented.

123. On a number of occasions, the Respondent knowingly and fraudulently billed DMA for performing alveoloplasties that were never performed.

124. For example, the treatment record for Patient Heather B., included in Investigative Panel Exhibit 25, indicates that Respondent extracted Heather B.'s tooth # 30 on August 27, 2008. Although the record does not indicate that an alveoloplasty was performed, the Respondent or his staff acting at his direction, billed DMA for performing an alveoloplasty during Heather B.'s August 27, 2008 appointment. Heather B. was approximately 14 years old as of August 27, 2008 and was not scheduled to receive a dental prosthesis.

125. On June 16, 2008, the Respondent or his staff, acting at his direction, knowingly billed DMA for performing four quadrants of scaling and root planing on a patient named Michael K. (Mr. K.).

126. Scaling and root planing is designed to treat periodontal disease in salvageable teeth.

127. On July 2, 2008, only 16 days after billing DMA for performing four quadrants of scaling and root planing on Mr. K's teeth, the Respondent applied to DMA for permission to extract all of Mr. K's remaining teeth and fabricate complete upper and lower dentures for him.

128. The scaling and root planing procedure for which the Respondent billed DMA on June 16, 2008 was useless since Mr. K's teeth were unsalvageable. The only effect that the scaling and root planing procedure had was to increase the fees collected by the Respondent.

129. The Respondent's conduct described in paragraphs 109-124 is further evidence that the Respondent's billing practices as described in this Final Agency Decision were part of a deliberate, dishonest scheme to defraud DMA of fees and were not the result of mistake or ignorance on Respondent's part.

130. The duration, breadth and scope of the billing practices in which the Respondent engaged that are set forth in detail in Finding of Fact 9-98 and 113-129 show that those billing practices were the result of a well thought-out and deliberate pattern or practice of submitting inflated bills that were materially false or misleading, rather than as the result of ignorance, misunderstanding or mistake. This pattern or practice, resulting in higher than legitimate payments for dental services, indicates a

dishonest motive and the intent to obtain money that the Respondent knew or should have known he was not entitled to receive.

Based upon the Findings of Fact and the consent of the parties, the Board hereby enters the following:

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the person of the Respondent and over the subject matter of this case.

2. The Respondent has sufficient comprehension of the English language to understand the requirements applicable to all dentists licensed in North Carolina, including the Board's rules and the rules applicable to dentists who treat Medicaid patients and seek payment for their services under applicable Medicaid rules.

3. The Respondent engaged in a deliberate pattern or practice of submitting inflated bills that were materially false or misleading to DMA for payment for treatment of Medicaid patients with the intent to obtain money that he knew or should have known he was not entitled to receive.

4. By knowingly and fraudulently billing DMA for conducting Code D0160 examinations without disclosing that he had not performed extensive, detailed evaluations and that the visits should have been billed at a lower paying code, the Respondent obtained or attempted to obtain fees through fraud, misrepresentation or deceit, in violation of N.C. Gen. Stat. § 90-41(a)(11), committed fraudulent or misleading acts in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(17) and engaged in acts violative of Article 2 of Chapter 90 of the North Carolina General Statutes, in violation of N.C. Gen. Stat. § 90-41(a)(6).

5. By knowingly and fraudulently billing DMA for performing four quadrants of scaling and root planing when four quadrants of scaling and root planing had not been completed, the Respondent obtained or attempted to obtain fees through fraud, misrepresentation or deceit, in violation of N.C. Gen. Stat. § 90-41(a)(11), committed fraudulent or misleading acts in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(17) and engaged in acts violative of Article 2 of Chapter 90 of the North Carolina General Statutes, in violation of N.C. Gen. Stat. § 90-41(a)(6).

6. By knowingly and fraudulently billing DMA for performing two separate fillings when in fact he had placed only one filling with multiple surfaces, the Respondent obtained or attempted to obtain fees through fraud, misrepresentation or deceit, in violation of N.C. Gen. Stat. § 90-41(a)(11), committed fraudulent or misleading acts in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(17) and engaged in acts violative of Article 2 of Chapter 90 of the North Carolina General Statutes, in violation of N.C. Gen. Stat. § 90-41(a)(6).

7. By knowingly and fraudulently billing DMA for full mouth debridements when in fact only prophylaxes had been performed, the Respondent obtained or attempted to obtain fees through fraud, misrepresentation or deceit, in violation of N.C. Gen. Stat. § 90-41(a)(11), committed fraudulent or misleading acts in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(17) and engaged in acts violative of Article 2 of Chapter 90 of the North Carolina General Statutes, in violation of N.C. Gen. Stat. § 90-41(a)(6).

8. By knowingly and fraudulently billing DMA for performing alveoloplasties following the extraction of four or more teeth per quadrant when in fact he had

extracted fewer than four teeth per quadrant, the Respondent obtained or attempted to obtain fees through fraud, misrepresentation or deceit, in violation of N.C. Gen. Stat. § 90-41(a)(11), committed fraudulent or misleading acts in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(17) and engaged in acts violative of Article 2 of Chapter 90 of the North Carolina General Statutes, in violation of N.C. Gen. Stat. § 90-41(a)(6).

9. By performing medically unnecessary alveoloplasties, the Respondent violated the standard of care applicable to North Carolina dentists and thereby engaged in negligence in the practice of dentistry in violation of G.S. § 90-41(a)(12) and engaged in acts violative of Article 2 of the Dental Practice Act, in violation of G.S. § 90-41(a)(6).

10. By knowingly and fraudulently billing DMA for medically unnecessary alveoloplasties without revealing that the alveoloplasties were not medically necessary, the Respondent obtained or attempted to obtain fees through fraud, misrepresentation or deceit, in violation of N.C. Gen. Stat. § 90-41(a)(11), committed fraudulent or misleading acts in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(17) and engaged in acts violative of Article 2 of Chapter 90 of the North Carolina General Statutes, in violation of N.C. Gen. Stat. § 90-41(a)(6).

11. By knowingly and fraudulently billing DMA for surgically extracting A.H.'s tooth number 19, without disclosing that the tooth had no attachment to the bone and that a surgical extraction was not performed, the Respondent obtained or attempted to obtain fees through fraud, misrepresentation or deceit, in violation of N.C. Gen. Stat. § 90-41(a)(11), committed fraudulent or misleading acts in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(17) and engaged in acts violative of Article 2 of

Chapter 90 of the North Carolina General Statutes, in violation of N.C. Gen. Stat. § 90-41(a)(6).

12. By knowingly and fraudulently billing DMA for extracting J.D.'s tooth D, without disclosing that the tooth had nearly exfoliated as of July 17, 2008, the Respondent obtained or attempted to obtain fees through fraud, misrepresentation or deceit, in violation of N.C. Gen. Stat. § 90-41(a)(11), committed fraudulent or misleading acts in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(17) and engaged in acts violative of Article 2 of Chapter 90 of the North Carolina General Statutes, in violation of N.C. Gen. Stat. § 90-41(a)(6).

13. By failing to detect and note in the treatment record the decay on H.B.'s teeth A, I, J, L, S and T on October 18, 2006 and by directing his assistant to apply sealants to H.B.'s teeth A, I, J and T, the Respondent violated the standard of care applicable to North Carolina dentists and thereby engaged in negligence in the practice of dentistry, in violation of N.C. Gen. Stat. § 90-41(a)(12) and violated Article 2 of Chapter 90 of the North Carolina General Statutes, in violation of N.C. Gen. Stat. § 90-41(a)(6).

14. By failing to ensure that his staff properly applied sealants to C.B.'s teeth on March 5, 2008, the Respondent violated the standard of care applicable to North Carolina dentists and thereby engaged in negligence in the practice of dentistry, in violation of N.C. Stat. Gen. Stat. § 90-41(a)(12) and violated Article 2 of Chapter 90 of the North Carolina General Statutes, in violation of N.C. Gen. Stat. § 90-41(a)(6).

In addition to the foregoing Findings of Fact and Conclusions of Law regarding the violations charged in the Investigative Panel's Notice of Hearing, the Board makes

the following findings and conclusions regarding the evidence of mitigating and aggravating factors introduced at the hearing:

FINDINGS AND CONCLUSIONS REGARDING DISCIPLINE

1. The Respondent's misconduct is mitigated by the following facts:

   a. Respondent volunteered his services at several free dental clinics before he was notified of the Board's investigation of his billing practices. On one such occasion, he also volunteered the services of some of his employees.

   b. Respondent has not been previously disciplined by the Board.

2. Respondent's misconduct is aggravated by the following facts:

   a. Respondent has engaged in a pattern of misconduct, namely a scheme to defraud Medicaid of large amounts of money by billing for work that was not done, work that was medically unnecessary and by exaggerating the nature and scope of treatment performed.

   b. Respondent's misconduct occurred over a significant period of time and was therefore not the result of a single lapse of judgment or the heat of passion.

   c. Respondent failed to demonstrate genuine remorse or accept full responsibility for his misconduct.

   d. DMA was fraudulently deprived of substantial sums of money as a result of the Respondent's dishonesty. Those funds could have been used to provide much-needed dental services to other indigent citizens of our state, including children.

e. Respondent's misconduct was driven by greed. He used much of the gains of his dishonest and fraudulent scheme to fund an opulent lifestyle, including purchasing a house worth nearly $1 million dollars, condominiums in Myrtle Beach, South Carolina, tracts of land in North Carolina, expensive cars and a new office building.

3. The Hearing Panel finds that the Respondent's payments of partial restitution to DMA are not mitigating factors because they were made shortly before the trial of this case.

4. The aggravating factors outweigh the mitigating factors.

5. Much of the Respondent's conduct involved dishonesty, a significant character flaw in a professional entrusted with the health and safety of the citizens of North Carolina. The Respondent failed to demonstrate that he has taken any steps to rehabilitate himself. Consequently, if the Respondent is permitted to practice, the Hearing Panel finds that there is a risk that he will engage in further misconduct.

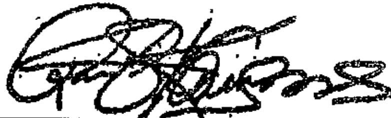
6. The Respondent's misconduct involved such a gross violation of the Dental Practice Act and the rules of ethics governing professionals that the Hearing Panel finds that revocation is the only discipline sufficient to protect the public.

Based on the foregoing Findings of Fact and Conclusions of Law, the Board enters the following:

ORDER OF DISCIPLINE

The Respondent's license to practice dentistry in North Carolina should be and hereby is REVOKED, effective April 18, 2011. Respondent shall surrender his license and current renewal certificate to the Board at its offices no later than April 18, 2011.

This the 17th day of March, 2011.



Ronald K. Owens, D.D.S., President
The N.C. State Board of Dental Examiners