BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

In The Matter Of:	)	
	)	**FINAL AGENCY**
John S. Won, D.D.S.	)	**DECISION**
(License No. 7202)	)	

THIS MATTER was heard before the North Carolina State Board of Dental Examiners ["Board"] on April 14-17, 2016, pursuant to N.C. General Statute §§ 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. William M. Litaker, Jr., presiding, Dr. Millard W. Wester, III, Dr. Merlin W. Young and Dr. David A. Howdy. Board members Dr. Stanley L. Allen, Carla J. Stack, RDH, and E. Clark Jenkins did not participate in the hearing, deliberation or decision of this matter. Carrie E. Meigs and Justin G. May represented Respondent, Dr. John S. Won ["Respondent"]. Douglas J. Brocker and K. Brooke Ottesen represented the Investigative Panel, and Thomas F. Moffitt represented the Hearing Panel.

Based upon the stipulations of the parties and the evidence introduced 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. Respondent was licensed to practice dentistry in North Carolina on June 22, 2000 and holds license number 7202. When referred to herein concerning any action or failure to act, the term, "Respondent" also refers to Dr. John S. Won's dental

practice and includes employees, agents or others under his control or acting at his direction.

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

4. At all times relevant hereto, Respondent worked as an oral surgeon with his primary office in Cary, North Carolina and solely owned his dental practice through John S. Won, D.D.S., M.D., P. A.

5. Respondent was properly served with the pleadings in this matter and had appropriate and adequate notice of the hearing dates.

Paul M.'s Death Following Surgery by Respondent

6. On February 23, 2010, Paul M. presented to Respondent's office for extraction of his remaining teeth. Respondent had not previously treated, seen, or consulted with Mr. M.

7. Respondent was the only dentist present in his office on February 23, 2010.

8. Respondent had nine (9) surgeries scheduled before Paul M.'s 10 a.m. appointment. Respondent had scheduled three (3) other surgeries and a consultation between 10 a.m. and 11 a.m. and scheduled three (3) additional surgeries and a follow-up appointment between 11 a.m. and noon. Respondent also had scheduled eleven (11) consultations and a follow-up appointment between 1:00 p.m. and 4:15 p.m. that afternoon.

9. In 2010, the applicable standard of care in North Carolina required dentists to allow sufficient time between appointments to permit them to provide adequate patient assessments, examinations, pre-surgical care, surgery and post-operative care.

10. Respondent failed to allow sufficient time between appointments to permit him to provide an adequate patient assessment, examination, pre-surgical care, surgery and post-operative care to Paul M. on February 23, 2010.

11. For example, according to Respondent's anesthesia and treatment records, there were only five (5) minutes, at most, between when Respondent

completed the previous surgery on patient Robert W. at 11:51 AM and when he began administering anesthesia to Paul M. on 11:56 AM.

12. Additionally, according to Respondent's anesthesia and treatment records for that same date and others, there were only 1-2 minutes, at most, between when Respondent completed the previous surgery on several patients and when he began administering anesthesia to the next patient.

13. Respondent's treatment records of a purported examination of Paul M. and other patients were identical or substantially the same templates for most or all patients and were not completed or modified to the patient's individual circumstances.

14. In 2010, the applicable standard of care in North Carolina required dentists to conduct and document a physical examination prior to performing oral surgery or administering anesthesia.

15. Respondent failed to conduct, or failed to document that he conducted, an adequate physical examination of Paul M. on or before February 23, 2010, prior to performing oral surgery or administering anesthesia.

16. In 2010, the applicable standard of care in North Carolina required dentists to conduct and to document an adequate patient assessment prior to performing oral surgery or administering anesthesia.

17. Respondent failed to conduct an adequate patient assessment of Paul M. on or before February 23, 2010, prior to performing oral surgery or administering anesthesia.

18. In 2010, the applicable standard of care in North Carolina required dentists to keep complete and accurate records of dental procedures performed on each patient.

19. Respondent failed to keep complete and adequate records for Paul M.'s February 23, 2010 visit and treatment.

20. During Paul M.'s February 23, 2010 oral surgery, Respondent elevated mucoperiosteal flaps and surgically removed Paul M.'s teeth numbers 11 – 26, and billed for performing alveoloplasty on all four quadrants and tuberosity reduction.

21. In 2010, the applicable standard of care in North Carolina required dentists who performed mucoperiosteal flap elevations, tuberosity reduction, alveoloplasty and

surgical removal of teeth to reapproximate the mucoperiosteal flaps into normal anatomic position and adequately suture them in place.

22. Respondent's treatment records for Paul M. do not indicate that he reapproximated the mucoperiosteal flaps into position and sutured them in place, except for teeth numbers 17 and 32.

23. Paul M. suffered significant bleeding from his gums following the surgical procedures performed by Respondent on February 23, 2010.

24. Paul M.'s family called Respondent's office and "informed them of the bleeding and also that the patient had vomited up some coffee-ground emesis which was thought to be swallowed blood," according to Paul M.'s hospital records and other evidence.

25. Paul M. was found unresponsive on the evening of February 24, 2010, and 911 was called. Paul M. was found by paramedics without a pulse, received CPR, and was taken to Wake Med Hospital.

26. Paul M. was admitted to Wake Med Hospital on February 24, 2010 for cardiac arrest secondary to hemorrhagic shock, which was found to be related to a significant amount of blood loss related to his dental procedure, according to the hospital records.

27. The treating ENT noted in Paul M.'s hospital records that he was "able to visualize mandibular gums which were found to be split open with no teeth."

28. Upon admission to Wake Med Hospital, Paul M.'s gums were profusely bleeding from the gingival region where his teeth were extracted and an unsuccessful attempt was made to suture his bleeding gums, according to his hospital records.

29. Less than 48 hours after Respondent performed oral surgery on Paul M., Paul M. went into cardiac arrest again and died at 10:19 AM on February 25, 2010.

30. Dr. James R. Lakey, one of Paul M.'s treating physicians at Wake Med Hospital, testified to a reasonable degree of medical certainty that the cause of Paul M.'s death was related to a significant amount of blood loss related to his dental procedure. The Hearing Panel found Dr. Lakey's testimony credible and more credible

on this issue than Respondent's expert witness, who had only reviewed the patient records and had no involvement in Paul M's treatment or care.

31. The Investigative Panel also presented the testimony of Dr. John Matheson, D.D.S. and related written reports and documents. Dr. Matheson testified and presented evidence that Respondent's evaluation and treatment of Paul M. violated the standard of care and caused or contributed to his death. The Hearing Panel found Dr. Matheson's testimony credible and more credible on these issues than Respondent's expert witness.

Fraudulent Billing, Misrepresentation, and Deceit of Medicaid

32. At all times relevant hereto, Respondent was an approved dental provider for the North Carolina Division of Medical Services ["DMA" or "Medicaid"] and was required to abide by all Medicaid billing policies and guidelines, ensure that his invoices were accurate, and submit timely corrections of any erroneous invoices.

33. At all times relevant hereto Medicaid required its providers to submit bills for their services using the codes set out in the American Dental Association's ["ADA"] Code of Dental Terminology ["CDT"].

34. At all times relevant hereto, Respondent, or someone at his direction or under his control, signed and submitted to DMA Provider Administrative Participation Agreements and Letters of Attestation agreeing to abide by all applicable billing policies and guidelines and to avoid fraud, waste and abuse.

35. From at least 2009-11, Respondent fraudulently and repeatedly billed, misled, and deceived Medicaid by routinely submitting claims for numerous CDT codes that misrepresented the services he provided to patients to obtain payment and reimbursement from DMA, including for the CDT codes set forth herein.

Fraudulent Billing of Code D9610

36. At all times relevant hereto, CDT Code D9610 could be properly billed when a dentist administered a single, parenteral dose of a therapeutic drug including antibiotics, steroids, and anti-inflammatory drugs, and the drug, dosage, and rationale

was identified in the patient's dental record and on the claim filed with DMA. Code D9610 could not be billed for administering sedative, anesthetic, or anesthetic reversal agents.

37. Respondent fraudulently billed, misled and deceived Medicaid on numerous occasions by submitting claims using Code D9610 when Respondent had not administered a single parenteral dose of a therapeutic drug and did not identify the drug, dosage, and rationale in the patient's dental record.

38. For example, for patient Corey D., Respondent submitted claims to DMA for performing extractions and alveoloplasty, and administering general anesthesia on March 18, 2009 and also used CDT Code D9610.

39. Respondent's patient record for Corey D. did not identify a drug, dosage, and rationale for administering a therapeutic drug separate from the anesthesia or sedative regimen.

40. Additionally, for patient Nivea G., Respondent submitted claims to DMA for performing extractions and alveoloplasty, and administering general anesthesia on March 18, 2009 and also used CDT Code D9610.

41. Respondent's patient record for Nivea G. did not identify a drug, dosage, and rationale for administering a therapeutic drug separate from the anesthesia or sedative regimen.

42. Drugs administered as part of the anesthesia or sedative regimen that have other potential therapeutic effects, such as Fentanyl and Versed, and which do not specify in the patient record a separate rationale for administering them, cannot also be used to submit separate claims under Code D9610.

43. Submitting such claims under Code D9610, in addition to submitting the applicable anesthesia code(s), results in billing Medicaid twice for administering the same drug to the same patients.

44. Respondent routinely misrepresented to DMA that he administered a single parenteral dose of a therapeutic drug when it had not been done and had not been properly documented by submitting claims to Medicaid using CDT Code D9610, including for the example patients referenced in this section and numerous others.

45. In reliance upon his misrepresentations, Medicaid reimbursed Respondent for administering therapeutic drugs that had not been provided and properly documented, including for the example patients referenced in this section and numerous others.

46. The payments by Medicaid under CDT Code D9610 were in addition to reimbursing Respondent under the appropriate anesthesia code(s) for those patients.

47. Medicaid paid Respondent approximately $150,000 collectively for all claims that he submitted to DMA for reimbursement under Code D9610 between January 1, 2009 and August 31, 2011.

Fraudulent Misuse of Code D0160

48. At all times relevant hereto, CDT Code D0160 was properly used when a dentist performed a detailed and extensive, problem-focused oral evaluation, involving integration of extensive diagnostic and cognitive modalities to develop a treatment plan for a specific problem, such as conditions requiring multi-disciplinary consultation, among others. The provider must describe and document the complicated or complex condition in the patient record.

49. Respondent fraudulently billed, misled, and deceived DMA on numerous occasions by submitting claims using CDT Code D0160 when he had not performed a detailed and extensive, problem-focused oral evaluation and did not describe and document his evaluation of a complicated or complex condition in the patient record.

50. For example, Respondent submitted claims to DMA for patient Corey D. for performing extractions, alveoloplasty, and administering general anesthesia and also under CDT Code D0160.

51. Respondent's patient record for Corey D. did not indicate that Respondent performed a detailed and extensive, problem-focused oral evaluation and did not describe and document his evaluation of a qualifying complicated or complex condition.

52. Additionally, for patient Nivea G., Respondent submitted claims to DMA for performing extractions, alveoloplasty, and for administering general anesthesia and also under CDT Code D0160.

53. Respondent's patient record for Nivea G. did not indicate that Respondent performed a detailed and extensive, problem-focused oral evaluation and did not describe and document his evaluation of a qualifying complicated or complex condition.

54. Evaluation or assessment of a patient for relatively routine oral surgery, such as extractions and alveoloplasty, including any documentation of such a routine evaluation did not qualify or warrant submitting a claim under CDT Code D0160.

55. Respondent misrepresented to DMA that he performed a detailed and extensive, problem-focused oral evaluation and that he documented in the patient record his evaluation of a qualifying complicated or complex condition, including by submitting claims to Medicaid under CDT Code D0160 for the example patients referenced in this section and numerous others.

56. In reliance upon his misrepresentations, DMA reimbursed Respondent for performing detailed and extensive, problem-focused oral evaluations of a complicated or complex condition and documenting such evaluations, which he had not done, including for the example patients referenced in this section and numerous others.

57. Medicaid paid Respondent approximately $324,500.00 collectively for all claims that he submitted to DMA for reimbursement under CDT Code D0160 between January 1, 2009 and August 31, 2011.

Fraudulent Submission of Medically Unnecessary CT Scans

58. Respondent fraudulently billed, misled or deceived DMA on numerous occasions by submitting claims for taking CT scans of his patients when CT scans were not medically necessary and where panorex radiographs would have been sufficient.

59. Respondent misrepresented to Medicaid that the CT scans were medically necessary, including by submitting claims for CT scans.

60. For example, Respondent submitted claims to DMA for taking a CT scan of patient Corey D. when the CT scan was not medically necessary and where a panorex radiograph would have been sufficient.

61. Additionally, Respondent submitted claims to DMA for taking a CT scan of patient Nivea G. when the CT scan was not medically necessary and where a panorex radiograph would have been sufficient.

62. In reliance upon his misrepresentations, Medicaid reimbursed Respondent for performing CT scans that were not medically necessary, including for the example patients referenced in this section and numerous others.

63. At all times relevant hereto, the Medicaid reimbursement rate was higher for CT scans than for panorex radiographs.

64. Medicaid paid Respondent approximately $170,000 collectively in 2009 for all claims that he submitted to DMA for reimbursement for taking CT scans.

Fraudulent Billing for Nitrous Oxide

65. CDT Code D9230 is designated for "Analgesia, anxiolysis, inhalation of nitrous oxide." CDT Code D9230 may be properly billed when an approved provider administers nitrous oxide to a patient.

66. Respondent fraudulently billed, misled, and deceived Medicaid on numerous occasions by submitting claims using CDT Code D9230 for administering nitrous oxide to patients when no nitrous oxide was administered.

67. For example, Respondent submitted claims to DMA for patient Corey D. including using CDT Code D9230 for administering nitrous oxide when no nitrous oxide was administered to Corey D.

68. Additionally, Respondent submitted claims to DMA for patient Nivea G., including using CDT Code D9230 for administering nitrous oxide when no nitrous oxide was administered to Nivea G.

69. To the extent CDT Code D9230 might apply to any drugs other than inhalation of nitrous oxide, drugs administered as part of the anesthesia or sedative regimen that have potential analgesic or anxiolytic effects, such as Fentanyl and Versed, cannot also be used to submit separate claims under Code D9230.

70. Respondent misrepresented to Medicaid that he administered nitrous oxide to patients to whom he had not provided it, including by submitting claims to Medicaid

under CDT Code D9230 for the example patients referenced in this section and numerous others.

71. In reliance upon his misrepresentations, Medicaid paid Respondent for administering nitrous oxide to patients to whom he had not provided it, including for the above example patients referenced in this section and numerous others.

72. Medicaid paid Respondent approximately $190,000 collectively for all claims that he submitted to DMA for reimbursement under CDT Code D9230, between January 1, 2009 and August 31, 2011.

Fraudulent Billing for General Anesthesia

73. At all times relevant hereto, CDT Code D9220 was properly used to bill for the first 30 minutes of general anesthesia, and CDT Code D9221 was properly used to bill for each additional 15 minutes of general anesthesia administered by a dentist while the dentist remained in continuous attendance of the patient.

74. Anesthesia services were considered completed when the patient could be safely left under the observation of trained personnel and the dentist could leave the room to attend to other patients or duties.

75. Respondent fraudulently billed, misled, and deceived Medicaid on numerous occasions by submitting claims using CDT Code D9221 for administering more than 30 minutes of general anesthesia when 30 minutes or less of general anesthesia had actually been administered while he remained in continuous attendance of the patient.

76. For example, Respondent submitted claims to DMA for patient Corey D. and used CDT Code D9221 for administering more than 30 minutes of general anesthesia, for a total of 90 minutes, where Respondent administered less than 30 minutes of anesthesia while he remained in continuous attendance of the patient.

77. Additionally, Respondent submitted claims to DMA for patient Nivea G. for administering more than 30 minutes of general anesthesia, for a total of 75 minutes, where Respondent administered less than 30 minutes of anesthesia while he remained in continuous attendance of the patient.

78. Respondent misrepresented to Medicaid that he administered general anesthesia to patients while he remained in continuous attendance by submitting claims to Medicaid using CDT Code D9221, including for the example referenced in this section and numerous others.

79. Respondent routinely submitted claims to DMA using CDT Codes D9220 and D9221 that collectively totaled more than the number of hours his office was open on that day.

80. Respondent also repeatedly submitted claims to DMA using CDT Codes D9220 and D9221 that collectively totaled more than 24 hours in a single day.

81. For instance, on March 18, 2009, when Respondent was the only treating dentist present in his office, Respondent submitted claims to Medicaid using CDT Codes D9220 and D9221 that collectively totaled 39 hours of general anesthesia billed on that single day.

82. In reliance upon his misrepresentations, Medicaid paid Respondent for administering general anesthesia for time periods during which he did administer general anesthesia or did not remain in continuous attendance of the patient.

83. Medicaid paid Respondent approximately $936,000.00 collectively for all claims that he submitted to DMA for reimbursement under CDT Code D9221, between January 1, 2009 and August 31, 2011.

84. The $936,000.00 amount does not include the amounts Medicaid paid Respondent using CDT Code D9220 for the first 30 minutes of anesthesia in this same time frame.

Fraudulent Billing of Alveoloplasty Code

85. At all times relevant hereto, CDT Code D7311 was properly used when a dentist performed an alveoloplasty if one to three teeth were extracted or missing per quadrant when preparing a ridge for dentures.

86. CDT Code D7310 was properly used when a dentist performed an alveoloplasty if four or more teeth per quadrant were extracted or missing when preparing a ridge for dentures.

87. Medicaid's reimbursement rate for Code D7310 was higher than that for Code D7311 during the relevant time period.

88. Respondent fraudulently billed, misled, and deceived Medicaid on numerous occasions for performing alveoloplasty by submitting Code D7310 even though fewer than four teeth were missing or extracted per quadrant or alveoloplasty was not performed to prepare a ridge for dentures.

89. For example, Respondent submitted claims to DMA for patient Kristin C. for performing alveoloplasty in all four quadrants on April 6, 2010, using CDT Code 7310, where Respondent extracted only a single tooth, the third molar in each quadrant.

90. Additionally, Respondent submitted claims to DMA for patient Alicia S. for performing alveoloplasty in all four quadrants on March 31, 2010, using CDT Code 7310, even though Respondent extracted only a single tooth, the third molar in each quadrant.

91. Respondent misrepresented to Medicaid that he had performed alveoloplasties with four or more teeth extracted or missing per quadrant and in preparing a ridge for dentures, when he had not done so, including by submitting claims to Medicaid using CDT Code D7310 for the example patients referenced in this section and numerous others.

92. In reliance upon his misrepresentations, Medicaid reimbursed Respondent for performing alveoloplasties using CDT Code D7310, including for the example patients referenced in this section and numerous others.

93. Medicaid paid Respondent approximately $434,000.00 collectively for all claims that he submitted to DMA for reimbursement under CDT Code D7310, between January 1, 2009 and August 31, 2011.

Fraudulent Billing of Surgical Extraction Code 7241

94. At all times relevant hereto, CDT Code D7241 was properly used when a dentist removed an impacted tooth, completely bony, with unusual surgical complications.

95. Respondent fraudulently billed, misled, and deceived DMA on numerous occasions by submitting Code D7241 when he had not removed an impacted tooth, completely bony, with unusual surgical complications.

96. For example, Respondent submitted claims to DMA for patient Corey D. for performing four (4) extractions on March 18, 2009, using CDT Code D7241 for each extraction, where Respondent did not remove completely bony and impacted teeth with unusual surgical complications.

97. Additionally, Respondent submitted claims to DMA for patient Brandon H. for performing four (4) extractions on March 18, 2009, using CDT Code D7241 for each extraction, where Respondent did not remove completely bony and impacted teeth with unusual surgical complications.

98. Respondent misrepresented to Medicaid that he had performed extractions of impacted teeth, completely bony, with unusual surgical complications when he had not done so, including by submitting claims to Medicaid using CDT Code D7241 for the example patients referenced in this section and numerous others.

99. In reliance upon his misrepresentations, Medicaid reimbursed Respondent for performing extractions of impacted teeth, completely bony, with unusual surgical complications when he had not done so, including for the example patients referenced in this section and numerous others.

100. Medicaid paid Respondent approximately $656,000.00 collectively for all claims that he submitted to DMA for reimbursement under CDT Code D7241, between January 1, 2009 and August 31, 2011.

Fraudulent Billing of Surgical Extraction Code D7210

101. At all times relevant hereto, CDT Code D7210 was properly used when a dentist surgically removes an erupted tooth requiring both elevation of a mucoperiosteal flap and removal of bone or sectioning of a tooth.

102. Respondent fraudulently billed, misled, and deceived Medicaid on numerous occasions by submitting Code D7210 when he had not removed an erupted

tooth requiring both elevation of a mucoperiosteal flap and removal of bone or sectioning of the tooth.

103. For example, Respondent submitted claims to DMA for patient Sonia H. for performing two (2) extractions on March 18, 2009, using CDT Code D7210 for each extraction, where Respondent did not remove bone or section the teeth.

104. Additionally, Respondent submitted claims to DMA for patient Carol H. for performing four (4) extractions on March 18, 2009, using CDT Code D7210 for each extraction, where Respondent did not remove bone or section the teeth.

105. Respondent misrepresented to Medicaid that he had surgically removed an erupted tooth that required both elevation of a mucoperiosteal flap and removal of bone or sectioning of the tooth when such surgical extraction was not required, including by submitting claims to Medicaid using CDT Code D7210 for the example patients referenced in this section and numerous others.

106. In reliance upon his misrepresentations, Medicaid reimbursed Respondent for a surgical extraction, when such surgical extraction was not required, including for the example patients referenced in this section and numerous others.

107. Medicaid paid Respondent approximately $1,118,000.00 collectively for all claims that he submitted to DMA for reimbursement under CDT Code D7210, between January 1, 2009 and August 31, 2011.

108. The Investigative Panel presented the testimony of Dr. Mark W. Casey, DDS, MPH, Dental Director of DMA. Dr. Casey testified concerning the application, interpretation, and administration of DMA Dental Services Clinical Coverage Policies and NC Medicaid Dental Reimbursement Rates, both of which incorporate and utilize the ADA CDT Codes. The Hearing Panel found Dr. Casey's testimony on these issues to be credible and worthy of deference, as the Dental Director of DMA.

109. The Investigative Panel also presented the testimony of Dr. John Matheson, D.D.S. and related written reports and documents. Dr. Matheson testified that Respondent's billing for Medicaid patients routinely was not warranted or justified. The Hearing Panel found Dr. Matheson's testimony on these issues to be credible.

Recordkeeping Deficiencies

110. At all times relevant hereto, the applicable standard of care in North Carolina required that dentists maintain adequate, complete, and accurate records for each patient.

111. Respondent did not maintain adequate, complete, and accurate records for each patient.

112. For example, in the record for patient Corey D., Respondent utilized template language without completing or customizing the template language for his particular circumstances, failed to document a physical examination prior to performing oral surgery, and failed to keep complete and accurate records of the dental procedures performed.

113. Additionally, in the record for patient Nivea G., Respondent utilized template language without completing or customizing the template language for his particular circumstances, failed to document a physical examination prior to performing oral surgery, and failed to keep complete and accurate records of the dental procedures performed.

114. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by not maintaining complete and accurate records for the example patients referenced in this section and numerous others, including but not limited to:

a. utilizing template language for each patient's chart without completing or customizing the template language for each patient's individual circumstances;
b. failing to document a physical examination prior to performing oral surgery; and
c. failing to keep complete and accurate records of dental procedures.

Intake, Health History, Examination, and Treatment Planning

115. At all times relevant hereto, the applicable standard of care in North Carolina required that dentists conduct a proper intake, comprehensive health history, examination, and treatment planning for each patient.

116. Respondent did not conduct a proper intake, comprehensive health history, examination, and treatment planning for each Medicaid patient, including for patients Corey D. and Nivea G.

117. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by not conducting a proper intake, comprehensive health history, examination, and treatment planning for the example patients referenced in this section and numerous others.

118. The Investigative Panel presented the testimony of Dr. John Matheson, D.D.S. and related written reports and documents. Dr. Matheson testified and presented evidence that Respondent did not conduct a proper intake, comprehensive health history, examination, and treatment planning and did not maintain sufficient records for each Medicaid patient. He testified and presented evidence that Respondent's actions violated the standard of care and caused or contributed to patient harm, injury, or damage, including to Patient Paul M. The Hearing Panel found Dr. Matheson's testimony credible and more credible on these issues than Respondent's expert witness.

Respondent's Fraudulent and Dishonest Intent

119. Respondent effectively had two classes of patients, which were treated very differently in many respects, depending on whether they had private insurance ["private insurance patients"] or were covered by Medicaid ["Medicaid patients"].

120. Most private insurance patients were seen for a consultation, assessment, and examination in advance and before the day of surgery.

121. Respondent's surgery schedules for private insurance patients generally allowed sufficient time for each surgery and any necessary patient assessment and examination.

122. Respondent's billing for private insurance patients generally appeared to be consistent with the CDT codes for the procedures actually performed.

123. In stark contrast, Respondent's procedures, care, and submission of claims for Medicaid patients were very different than for his private insurance patients.

124. For example, virtually none of Respondent's Medicaid patients were seen for a consultation, assessment, and examination prior to the day of surgery.

125. Respondent's oral surgery schedule on days for Medicaid patients was very different from private insurance patients.

126. The schedules included many more Medicaid patients in a day than for private insurance patients.

127. For example, Respondent instructed his staff to schedule all five (5) of the operatories in his main office in Cary for every hour the dental practice was open on days he has treating Medicaid patients.

128. Respondent's schedules on days he has treating Medicaid patients did not provide for adequate patient assessments, examinations, and evaluations.

129. Respondent did little, if any, patient assessments, examinations, or evaluations prior to administering general anesthesia and performing surgery for Medicaid patients, according to Respondent's records and the testimony of his former employees. The Hearing Panel found the testimony of Respondent's former employees on this issue to be credible.

130. Respondent's submission of claims to DMA for Medicaid patients was significantly different than for private insurance patients.

131. Other than the surgical codes, most all of the codes that Respondent fraudulently billed to Medicaid were rarely billed for private insurance patients, even for similar patients at or around the same time.

132. Respondent's testimony and assertions that the improper submission of claims to DMA was caused by his former billing manager was contradicted and refuted by other evidence.

133. For example, Respondent continued to submit fraudulent claims to DMA in the same or similar manner for six months after the billing manager's termination and approximately until he was notified that he was under investigation.

134. The Hearing Panel did not find Respondent's testimony and assertions on these Medicaid billing issues to be credible.

135. The U.S. Government contended that during the dates of January 1, 2008 through December 31, 2011, Respondent submitted or caused to be submitted to Medicaid claims for payment in violation of the NC False Claims Act and in violation of the Medical Assistance Provider Claims Act.

136. Respondent reached a settlement agreement with the U.S. Government related to these allegations and agreed to repay Medicaid a total of 2.2 million dollars ($2,200,000.00).

137. Respondent's conduct and actions demonstrate that his billing practices and submission of false claims were not the result of mistake or ignorance, but rather part of a deliberate, dishonest plan or scheme to routinely and systematically defraud the Medicaid program by repeatedly charging and receiving reimbursement for unwarranted and unjustified charges on numerous patients over at least a several year period.

138. The duration, breadth, and scope of the billing practices in which Respondent engaged demonstrate his dishonest motive and the intent to obtain money that Respondent knew or should have known he was not entitled to receive.

Based upon the Findings of Fact, the Hearing Panel makes the following:

CONCLUSIONS OF LAW

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

2. Respondent violated the applicable standard of care in his treatment and care of Paul M. on February 23, 2010 by failing to:

a. allow sufficient time between appointments to conduct adequate patient assessments, examinations, pre-surgical care, surgery, and post-operative care;
b. conduct an adequate physical examination of Paul M.;
c. conduct an adequate patient assessment of Paul M.;
d. keep adequate, complete, and accurate records for Paul M.'s February 23, 2010 surgery and treatment; and
e. reapproximate the mucoperiosteal flaps into position and adequately suture them in place.

3. Respondent's violation of the standard of care in his treatment and care of Paul M. proximately caused or contributed to causing Paul M. harm, injury or damage.

4. Respondent was negligent in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(12), committed acts constituting malpractice in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(19), and engaged in acts violating Article 2 of Chapter 90 of the North Carolina General Statutes in violation of N.C. Gen. Stat. § 90-41(a)(6) in his treatment and care of Paul M. on February 23, 2010, as set forth in Conclusions of Law 2 and 3 and Findings of Fact 6-31.

5. Respondent obtained fees through fraud, misrepresentation, and deceit in violation of N.C. Gen. Stat. § 90-41(a)(11), committed fraudulent and misleading acts in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(17), engaged in such immoral conduct as to discredit the dental profession in violation of N.C. Gen. Stat. § 90-41(a)(10), 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), for the example patients specifically referenced in this Final Agency Decision and numerous others covered by Medicaid, as set forth in Findings of Fact 32-109 and 119-138, by:

a. routinely submitting false or fraudulent claims to DMA using Code D9610 and obtaining payment from Medicaid when Respondent had not administered a single parenteral dose of a therapeutic drug and had not identified the drug, dosage, and rationale in the patient's dental record;

b. routinely submitting false or fraudulent claims to DMA using CDT Code D0160 and obtaining payment from Medicaid when Respondent had not performed a detailed and extensive, problem-focused oral evaluation and had not described and documented in the patient record a qualifying complicated or complex condition;

c. routinely submitting false or fraudulent claims to DMA for taking CT scans of his patients and obtaining payment from Medicaid for them when the CT scans were not medically necessary and a panorex radiograph would have been sufficient;

d. routinely submitting false or fraudulent claims to DMA using CDT Code D9230 and obtaining payment from Medicaid for administering nitrous oxide to patients when Respondent had not administered nitrous oxide to the patients;

e. routinely submitting false or fraudulent claims to DMA using CDT Code D9221 and obtaining payment from Medicaid, when 30 minutes or less of general anesthesia had actually been administered while Respondent remained in continuous attendance of the patient;

f. routinely submitting false or fraudulent claims to DMA using Code D7310 and obtaining payment from Medicaid for performing alveoloplasty, even though fewer than four teeth were missing or extracted per quadrant or if alveoloplasty was not performed in preparing a ridge for dentures;

g. routinely submitting false or fraudulent claims to DMA using Code D7241 and obtaining payment from Medicaid when Respondent had not removed an impacted tooth, completely bony, with unusual surgical complications; and

h. routinely submitting false or fraudulent claims to DMA using Code D7210 and obtaining payment from Medicaid when he had not removed an erupted tooth requiring both elevation of a mucoperiosteal flap and removal of bone or sectioning of the tooth.

6. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina for the example patients specifically referenced in this Final Agency Decision and numerous others covered by Medicaid by:

a. not maintaining adequate, complete, and accurate patient records; and

b. failing to conduct a proper intake, comprehensive health history, examination, and treatment planning.

7. Respondent's violations of the standard of care set forth above proximately caused or contributed to causing harm, injury or damage to patients, including Paul M.

8. Respondent engaged in negligence in the practice of dentistry, in violation of G.S. 90-41(a)(12), including for Paul M., the example patients specifically referenced in this Final Agency Decision, and numerous others covered by Medicaid, as set forth in Conclusions 2,3, 6 and 7 and Findings of Fact 6-31 and 110-118.

In addition to the foregoing Findings of Fact and Conclusions of Law, the Hearing Panel makes the following findings and conclusions regarding mitigating and aggravating factors and other factors relevant to the appropriate discipline to impose:

ADDITIONAL FINDINGS AND CONCLUSIONS REGARDING DISCIPLINE

1. Respondent's misconduct is mitigated by the following:
   a. Respondent has not been previously disciplined by the Board; and
   b. Respondent has made partial restitution to DMA pursuant to a settlement agreement with the government.
2. Respondent's misconduct is aggravated by the following:
   a. Respondent's violations of the standard of care caused or contributed to Paul M's death;
   b. Respondent's disparate treatment of Medicaid patients and private insurance patients, including on issues that affected the quality of care and treatment provided;
   c. Respondent engaged in a deliberate, dishonest plan or scheme to routinely and systematically defraud the Medicaid program and to

enrich himself for his own personal gain, which intentional pattern of misconduct occurred over a significant period of time;

d. Respondent failed to demonstrate genuine remorse or accept full responsibility for his misconduct. Respondent consistently has attempted to place blame for his actions on others, including one or more of his former employees;

e. Medicaid was fraudulently deprived of substantial sums of money as a result of Respondent's dishonesty and misconduct. Those funds could have been used to provide much-needed dental services to other indigent citizens of our state; and

f. Respondent's misconduct was driven by greed. He used gains from his dishonest and fraudulent scheme to fund an opulent lifestyle.

3. The aggravating factors outweigh the mitigating factors.

4. Much of Respondent's conduct involved dishonesty, a significant character flaw in a professional entrusted with the health and safety of the citizens of North Carolina.

5. Respondent failed to demonstrate that he has taken steps to rehabilitate himself.

6. If Respondent is permitted to continue practicing dentistry, there is a risk that he will engage in further misconduct and pose a significant risk to the public.

7. Respondent's misconduct involved such serious, numerous violations of the Dental Practice Act and the rules of ethics governing professionals that revocation is the only discipline sufficient to protect the public.

8. Respondent's wide-ranging and lengthy pattern of misconduct warrants revocation, even if the Hearing Panel had not found each of the violations set forth in this FAD, or if his actions had not caused or contributed to the death of Paul M.

9. Each of the violations involving a pattern of intentional or fraudulent misconduct alone warrants revocation to protect the public.

Based on the foregoing Findings of Fact, Conclusions of Law, and Additional Findings and Conclusions Regarding Discipline, the Hearing Panel enters the following:

ORDER OF DISCIPLINE

Respondent's license to practice dentistry in North Carolina is REVOKED, which is effective sixty (60) days from service of this Final Agency Decision. Respondent shall surrender his license and current renewal certificate to the Board at its offices no later than the effective date of this Final Agency Decision.

This the 28 day of July, 2016.

William M. Litaker, DDS

William M. Litaker, DDS, Presiding Officer
The N.C. State Board of Dental Examiners